

THE STRUCTURAL AND ENVIRONMENTAL
DIMENSIONS OF FLORIDA'S CONTINUING CARE
RETIREMENT COMMUNITIES

By

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by

William Edward Folts

For Sandra,
who knew from the very beginning.

And dedicated to the memory of

Carol Ann Turner
Bob Cole
Thomas Michael Murphy

They left without realizing how important they were.
They are missed.

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Recent economic and social trends have fostered a renewed interest in the living arrangements of this nation's twenty-eight million elderly people. The modern continuing care retirement community grew out of a need for a supportive living environment for elderly people who had the financial resources to pay for support services but who, for a variety of reasons, could not locate those services in their more traditional living arrangements.

This dissertation describes multi-level care retirement communities as complex organizations operating in an uncertain and changing environmental context. Based upon data gathered at forty-one communities operating in the State of Florida, it is suggested that the concept of a continuum of care can be made more useful to

gerontologists if it is expanded to include living arrangements, housing types, and service types.

Florida has two distinct types of continuing care retirement communities. There are those that were established before the 1950s that tend to be affiliated with a particular religious or fraternal organization, and there are those that were the result of proprietary development in the last twenty-five years. The data suggest that not only have the more recent communities developed structural (organizational) characteristics based upon the experiences of the older communities, but the early communities have, as a result of regulatory requirements and a refining of the concept, adjusted to their operating environments by adopting strategies from the newer communities.

Recent organizational analyses have paid particular attention to the operating or "task" environment. One issue of concern is limiting the analysis to relevant elements in the environment. The data presented here suggest that there are five important elements in the operating environments of continuing care retirement communities.

CHAPTER ONE INTRODUCTION

Background

Recent economic trends and social developments have fostered a renewed interest in the living arrangements of this nation's twenty-eight million elderly people. Both the quantitative element of where they live and the qualitative element of how they live have been the foci of recent efforts by gerontological researchers and practitioners alike. An overwhelming majority of elderly people today live in single family homes that they themselves own, but an increasing number are choosing what have been loosely termed alternative living arrangements.

This dissertation describes multi-level care retirement communities as complex organizations operating in an uncertain environmental context. The main objectives are to identify the organizational and environmental components of these communities, to explore the linkages between and among these components, and to develop conceptual and research frameworks for the further study of multi-level care retirement communities and their organizational adaptation to environmental uncertainty.

The term "alternative living arrangements," as it is applied to elderly people, is a somewhat imprecise

residual category used to describe any of several living arrangements that are conceptually between total independence and total dependence. Put simply, it is used primarily to identify housing arrangements that are alternatives either to living alone or to living in a more or less dependent environment.

The term itself implies that there exists a continuum of housing alternatives consisting of graduated levels of support from living in one's own home to living in a nursing home. In studies by Streib, Folts, and Hilker (1984), Streib and Hilker (1980), Streib and Folts (1981), Streib, La Greca and Folts (1986), Streib and Haas (1983), Mangum (1979), and Lawton (1981), it has been suggested that persons who chose to live in the various alternative living arrangements studied did so because that lifestyle offered particular services that were needed, but that could not be reasonably obtained in their former and more traditional living arrangement.

Thus, the key element of alternative living arrangements would seem to be the provision, either formally or informally, of support services to individuals so that they can remain relatively independent for a longer period of time than if the services were not available.

The continuum of care, so often referred to by gerontologists, is a conceptual model that ranks living arrangements by the levels of support services that are provided. In general, the end points of the continuum are

presumed to be represented by independent living in a traditional dwelling unit on one end, and by living in a full care skilled nursing facility on the other end. The living arrangements between those end points are often lumped together into a single broad category which, for lack of a better term, is called "alternative living arrangements."

There are often only subtle differences among the living arrangements falling between the end points, and that has led to serious questions about the usefulness of such a model as a conceptual tool. Streib, Folts, and Hilker (1984) have suggested that part of the difficulty in ranking these facilities along a continuum is that services may be more or less informally delivered on an at need basis. Because of this, the type and level of services that are available within any particular living arrangement is flexible and is largely dependent upon the needs of a changing resident population.

Another fundamental question being argued at many levels is the social desirability of age concentrated living arrangements. On one side, there are those who believe that age concentration, or age segregation as it is also called, constructs physical, social, and intellectual ghettos into which elderly people are pushed. Others view age concentration as a means of providing a milieu wherein the common interests of elderly people can be pursued in an environment that is secure and to a large extent self directed.

The practical impact of the outcome of this debate is made moot, because however society views alternative living arrangements one thing is clear: more and more elderly people are choosing to live in age concentrated housing arrangements. And one of the more popular of these arrangements is the modern American retirement community.

Retirement Communities

Retirement communities represent one form of alternative living arrangement. However, they are diverse in their structure and in both the quality and quantity of services they offer (Streib, Folts, and Hilker, 1984). The result is that a wide variety of living arrangements are labeled as retirement communities. The essential elements of retirement communities were first delineated by Webber and Osterbind (1961, p.4). They have defined a retirement community as

A small community relatively independent, segregated, and non-institutional, whose residents are mainly older people separated more or less completely from their regular or career occupations in gainful or non-paid employment.

Admittedly, this definition can include many different types of living arrangements and addresses neither the organizational aspects of the community nor the physical layout of the actual dwelling units. However, it is still a widely accepted definition of just what constitutes a retirement community.

The facilities studied here, what we have called "multiple level care retirement communities," are a

special category of retirement community. They offer many of the same services that other retirement communities offer and what Streib, Folts, and Hilker (1984) have called the "leisure oriented lifestyle" is very much in evidence.

The fundamental difference is that these multiple level care communities offer health care and supportive services that are not found in the types of communities traditionally thought of as retirement communities. Another important difference is that the elderly people who are attracted to multiple level care retirement communities are people concerned about health matters. All the other services offered by these communities are undoubtedly important, but the single most important factor is that the developers or sponsors have created a reasonable expectation of the availability of health related care and support.

Life-Care and Continuing-Care Communities

Specifically, the term "multiple level care retirement community," as it is used here, refers to a rather narrow group of living arrangements including "life-care" and "continuing care" communities. In the past, these designations have been used somewhat interchangeably to refer to any facility offering health care as a part of a residency agreement.

The early life-care communities required the payment of an endowment or entrance fee. In return the potential

resident was guaranteed care, within the limits of the levels of care provided by the facility, for the duration of his or her life. In addition a monthly fee was charged depending upon the actual level of care provided. The facility guaranteed that during the lifetime of the resident the costs would not increase. Because of the financial failure of several of these early facilities (See Netting and Unks, 1984) protective legislation has dictated changes in the financial structures of such communities, and there has emerged another type that is presumably less vulnerable to financial or demographic miscalculations.

This new legislatively mandated structure usually places restrictions on the use of funds and requires that certain escrow accounts be established to insure continued operation even in the event of gross mismanagement by those in charge. The monthly fees tend to be higher and there may still be a guarantee of care for the life of the resident, but this system is designed to reduce the risks involved in predicting what care will cost and how long the individual will live to need that care.

It is specifically suggested here that the term "life-care" be reserved for only those facilities that guarantee lifelong care to the individual by contractual agreement. "Continuing care," it is suggested, should be a more inclusive term used for those facilities wherein there is the reasonable expectation of lifelong care,

whether or not there is a life-care contract. Thus, using the typology suggested here, all life-care communities are, by definition, continuing care communities, but not all continuing care communities are life-care communities.

The very fact that a community offers several different levels of care creates in the minds of the residents the reasonable expectation that when, and indeed if, they themselves need supportive care, it will be available to them. Thus, all communities that offer multiple levels of care, thereby creating in the minds of the residents the reasonable expectation of lifelong care, whether that expectation is guaranteed contractually or by an implied or informal agreement are, by this definition, continuing care retirement communities.

Gerontological Relevance

This study has both organizational and gerontological relevance for at least two reasons. First, because of the relative newness of the continuing care retirement community concept, little is known about them beyond the fact that they represent one option in the growing concern about housing and health care for elderly people. Because these communities are considered by many to be merely a special case of the more general category of housing called retirement communities, they have, until very recently, received little more than passing interest in the literature (Netting and Unks, 1984; Adelman, 1980; Winklevoss and Powell, 1981).

Although there is a clear tendency in the literature to define continuing care retirement communities as merely retirement communities that provide yet another service to their residents, albeit a somewhat unique service, it is asserted here that there are fundamental differences between them that warrant closer scrutiny.

These differences may be inferred from the fact that one type of organization is established to provide leisure activities to more or less healthy individuals, and the other organization is established to provide security to individuals who are now healthy but who anticipate debilitating physical conditions in the future.

Thus, even if there were no more differences than the differences in motives of those who move into these communities, subsuming continuing care communities under the general label "retirement community," particularly for research purposes, would seem to be unwarranted.

Organizational Relevance

Beyond the description of an emerging category of living arrangement for the elderly, the organizational characteristics of these communities are important because little information is presently available about the structural organization of such living arrangements. If strategies for dealing with a turbulent and changing environment are more than mere isolated and unique reactions to crisis situations, then exploring these communities as complex organizations will add to overall

understanding from both an organizational and a gerontological perspective. And, as will be discussed, there is evidence that these strategies are neither isolated nor unique.

The organizational literature is dominated by studies of profit oriented business firms. Although research has been done on non-profit organizations, little is known about how continuing care retirement communities behave as complex organizations. This study is a beginning attempt to bridge the gap between gerontological and organizational research.

Gerontologists in the United States have, in the very recent past, begun to formulate conceptual frameworks, the precursors to theory, aimed at explaining the empirical reality of growing old in a society that, at least on its surface, pretends to deify all that is youthful. As it became evident that the early attempts at gerontological theory building did not reflect empirical reality very well, attention was turned away from the intellectual concept of the impact of the "social" aging of an entire population, and toward the more immediately practical concept of how individuals responded to growing old. Organizational analysis, itself a relatively recent development, provides a conceptual framework through which an important phenomenon may better be understood and one which takes a broader perspective than the mere judgment of whether or not the resident population finds a particular milieu satisfactory.

Summary

Continuing care retirement communities represent one form of what can best be described as alternative living arrangements for older people. This particular type, and others, grew out of the need for support services by elderly people who could not find adequate substitutes in their more traditional living arrangements.

Although there is much debate, mostly among gerontologists and other advocates for the elderly as to the social desirability of age segregated or age concentrated living environments, the fact remains that elderly people continue to choose this type of living arrangement.

The modern multi-level care retirement community is a special category of retirement community that offers its residents health related support services in addition to the overall lifestyle.

Even though the two are related, "life-care" and "continuing-care" describe two separate housing concepts. It is suggested that one way to avoid confusing the two is to reserve the term "life-care" for only those cases where there exists a legal guarantee by the community that obligates it to care for the resident for his or her lifetime, irrespective of the ability of the community to fulfill that contract.

Continuing care, on the other hand, should be a more inclusive term including communities where there is a

reasonable expectation of lifetime care, regardless of whether there is a legal obligation to provide that care. The reasonable expectation of lifelong care is created by the fact that several different levels of care are offered at a single site, and all residents are given access to the support services within the limitations of their personal financial resources and the availability of space.

CHAPTER TWO REVIEW OF THE LITERATURE

Retirement communities have been a subject of interest to gerontologists for several decades. As early as the 1920s retirement "villages," precursors to the modern retirement community, were being developed to provide low cost housing to retired individuals self-selected because of membership in a particular religion or fraternal organization. At some point, roughly around 1960, changing attitudes toward retirement, and the concomitant increase in the number of healthy aged individuals with adequate post-retirement incomes, combined to produce a significant surge in both the number and the quality of what we now call retirement communities.

The period since that initial surge in development is marked by two distinct trends. First, the existence of a large population of healthy elderly people with adequate incomes attracted the attention of entrepreneurial developers. For the first time, retirement communities became profit-making ventures rather than altruistic expressions of religious or fraternal support. In order to attract residents, private developers began to design elaborate leisure and recreational programs as integral

elements of community life. In addition, although retirement communities retained their relative economic advantages over the same lifestyle in age integrated communities, emphasis was shifted from the retirement community as a low-cost housing alternative to the retirement community as a leisure oriented "lifestyle" choice.

Although the establishment of age concentrated communities can be traced to the efforts of religious and fraternal organizations attempting to meet the needs of their elderly members (Heintz, 1976; Haas, 1980; and Winklevoss and Powell, 1984), entrepreneurial developers, sensitive to the potential market for such services, have had a profound impact upon the development of the modern retirement community. In fact, the impetus to innovate is in large part due to direct competition among early developers in an attempt to attract a larger share of the "market" (Streib, La Greca, and Folts, 1986).

Much has been written about the motivations and the satisfaction of the individual residents of age segregated communities and most studies of retirement communities attempt to identify, at least in a cursory manner, the structural and organizational components (Jacobs, 1974; Heintz, 1976). Still, very little is known about the organizational relationship between retirement communities and their operating environments.

The second major trend in the evolution of the modern retirement community involves the delivery of health care

to residents. Although each of the terms life-care, continuing-care, and multiple-level care have, in the past, been used interchangeably to describe a wide variety of somewhat diverse living arrangements, all have in common the the reasonable expectation of housing and at least some level of medical care to be delivered, as needed, sometime in the future.

These continuing care retirement communities, as we shall call them here, represent a relatively recent and innovative concept combining elements of both housing and health care delivery to elderly people.

By the decade of the 1970s, retirement communities in general had significantly modified their somewhat unfavorable and long standing reputation as "low-cost" housing. To be sure, some stereotypical "trailer parks" remained, but as more and more affluent elderly people chose to live in the comparative luxury of the modern retirement community, these "trailer parks" began to be identified less with the elderly and more with low-income residents. Indeed, modern retirement communities began to be thought of in terms of their leisure and recreation oriented lifestyles. Still, in retrospect, there was a population of elderly people who were not as interested in recreational programs as they were in the delivery of health care services. More specifically, this population was concerned with the availability of nursing home care and the provision of support services that would allow them to avoid nursing care for a longer period of time.

The early retirement communities were largely unregulated. As these communities grew in size and complexity, governmental agencies began to require certain standards of operation. However, until retirement communities began to provide health care, what regulation that existed took the form of constraints on the business and accounting practices of those who developed and those who operated the communities, and physical placement regulations by zoning and planning commissions.

Providers of medical care have been more or less subject to regulation by various government agencies for much of our history and the nursing home components of continuing care retirement communities are no exception. However, the promise to provide health services is fundamentally different from the actual services themselves, and while the quality of care is regulated by licensing boards and the like, the promise to deliver those services is not.

Regulatory oversight is especially important in the special case of life-care communities because, absent outside regulation, the successful fulfillment of the promise to provide health care depends in large measure upon the developer's ability, and indeed his or her willingness, to commit financial support, either his or her own or that of investors, to a venture whose parameters are largely unknown.

The practical frailty of the promise to provide care for a lifetime, whether it is in contractual form or only

an informal expectation, was painfully brought out when, in 1977, no less than ten life-care communities located in California, Arizona, Florida, Hawaii, and Michigan filed for bankruptcy (Netting and Unks, 1984; Tonkin, 1981). Seven of these facilities were operated by the same corporation and were affiliated with the United Methodist Church whose underlying altruistic motives could hardly be questioned. In fact, all of the ten facilities were affiliated, in one way or another, with organized religious groups. Thus, it became quite apparent that, good intentions notwithstanding, regulatory mechanisms were needed.

Although there is no federal regulation of the life - care industry (Netting and Unks, 1984, p.26), the special need for oversight was recognized as early as 1953 by the Florida Legislature (Fla. Stat. 651.02(4)(1953); Fla. Stat. 651.02(4) (1975)). However, due to what Powell (1976) calls "statutory loopholes" (p.1019), most retirement communities providing health care to their residents could easily avoid regulation by minor changes in the wording of the contracts. Thus, by 1975, the Florida law was significantly broadened and strengthened because of what the legislature determined to be "(the) abusive business practices in the life-care industry" (Powell, 1976, p. 1017).

Regulation has had two main effects on life-care communities--it has placed limits on where and when such

communities may be constructed and it has defined a minimum financial commitment that is required from investors. In this sense, regulation has served both as a protective and a predictive device. However, it is still the case that retirement communities, whether they are life-care, continuing care, or leisure oriented communities, operate in an organizational environment that is, in the typology first suggested by Dill (1958), heterogeneous, shifting, and segmented.

Although neither field has directly addressed the issue of continuing care retirement communities as complex organizations, both the gerontological and the organizational literature offer important insights that provide the basis for such an analysis.

Retirement Communities

The recent gerontological literature dealing with retirement communities may be described as concerning itself with two main topics: age segregation and resident satisfaction. Perhaps because the "modern" retirement community emerged only recently, researchers have been preoccupied with the individual residents of these communities. Although much can be found in the literature regarding both the demographic as well as the socioeconomic characteristics of those who choose this lifestyle, and although almost all of these studies pay limited attention to the organizational structure of retirement communities, still there exists no research

that deals directly with the retirement community as a complex organization.

In one study, Jacobs (1974) has presented a view of retirement communities that reflects a generally negative assessment. However, the cumulative findings of those who have studied them suggests that age concentrated environments are not only a preferred living arrangement for some elderly, but those who actually live in them tend to be highly satisfied with the lifestyle (Barker, 1966; Bultena and Wood, 1969; Malozemoff et al., 1978; Messer, 1967; Osgood, 1982; Rosow, 1967; Teaff et al., 1978; and Streib, et.al., 1986).

Indeed, so convincing are the data, that among the critics of retirement communities (for example Maggie Khun of the Gray Panthers), the argument appears to be shifting away from issues relating to life satisfaction toward an almost exclusive concern with the issue of age segregation.

Implied in the literature of researcher and critic alike, is an attempt to come to terms with the question of whether elderly people have common needs that can be met more efficiently, in a social sense, by concentration of those needs, (i.e., literally and physically concentrating the elderly in one area) or is the whole retirement community enterprise an attempt to push elderly people out of the main stream of society.

Studies of retirement communities have generally viewed them as aggregations of individuals acting in their own best interest. To be sure, that perspective is vitally important in understanding the phenomenon; however, there has not as yet been any analysis that views the community as a complex organization, with a "life of its own," so to speak. This perspective requires that the community itself be viewed as more than a summation of the characteristics of the individuals who live in it.

There is no reason to believe that the emphasis on the individual residents of retirement communities will occupy any less importance in the future. However, there has been at least one exception to this general trend. In a recent study by Streib, La Greca, and Folts (1985; 1986), thirty-six retirement communities were studied and many interesting structural regularities were discovered. One of the most interesting of the findings was that, although each community had developed structural dimensions that were related to unique and local operational concerns, there were many structural dimensions that were extraordinarily similar. In fact, in a preliminary paper (La Greca, Streib, and Folts, 1984) this study established common "life-stages" through which retirement communities are believed to pass. The results of this research are just now beginning to be analyzed in depth, but it represents one attempt to view the retirement community as the unit of analysis and to

establish organizational regularities that contribute to the survival of the community.

In a recent study of continuing care retirement communities, Winklevoss and Powell (1984), obtained data from 207 communities that were actually in operation at the time. Their attempt to identify CCRCs and to explore the characteristics of the phenomenon remains as the only nationwide study of this particular living arrangement. Although their data were directed at an economic analysis of continuing care, the study clearly established that continuing care retirement communities were indeed complex and in need of further definition.

That such communities are indeed complex organizations may be derived from any of the many definitions in the organizational literature. See, for example, Miles (1980, p.5) or Aldrich (1979, p.4).

One need only look through the incorporation papers, legal documents, and other documents relating to the organizational structure of retirement communities to reaffirm the assertion that they do indeed represent a special type of complex organization. And, although retirement communities are obviously not manufacturing firms, at least in the traditional sense, they do indeed produce a product, in the form of a living arrangement and lifestyle, that is at least as palpable as that produced by financial institutions or brokerage firms. Less obvious but just as important is the idea that these communities

have inputs, throughputs, outputs, and even technologies that link them with the less subtle manufacturing firms.

Quite apart from the intuitively reasonable assertion that retirement communities are, by their very nature, goal directed, boundary maintaining, activity systems; it is clear that recent studies of retirement communities (Streib, La Greca, and Folts, 1984; 1986), although sometimes quite unintentionally, have established them as organizations with complex structural elements and with a collective "personality" that is not unlike the business firm.

The assertion that continuing care retirement communities are complex organizations implies that they are more than merely a combination of housing and supportive care. Specifically it implies that they are made up of an interacting set of components that are purposefully arranged so as to provide a variety of patterned services that more or less meet the needs of those who choose to live in them. In his work on hospitals Georgopoulos states

(The general hospital is) . . . many different, but interlocking and interdependent parts-- departments, staffs, positions, and work roles. It is a highly specialized and internally differentiated system which is intended to do certain work in order to solve particular human problems. (1972, p.9)

So too, the continuing care retirement community has evolved into a collection, an organization if you will, of specialized and differentiated parts, coordinated for the purpose of providing a supportive living arrangement for

elderly people. These differentiated parts interact with each other and with elements of the organization's environment in an attempt to balance the organization's need to exist with the environmental demands placed upon it. To the extent that this balance is achieved, in a global sense, then the continuing care retirement community can be said to be effective.

The Organizational Perspective

The development of organizational theory may be conveniently divided into two distinct phases or approaches. These have been identified by Thompson (1967), Shafritz and Whitbeck (1978), Aldrich (1979), Zey-Ferrell (1979), Perrow (1973), Scott (1981a), and others, as the closed-system approach, identified with the works of Weber (1978); and, the open-system approach, identified with Barnard (1938), Selznick (1949), and Clark (1956).

The closed system approach to organizations is exemplified by Weber's bureaucratic ideal type in that each organization is assumed to be rationally striving for a well defined goal. In addition, the efficiency of an organization is viewed as an indicator of its effectiveness. This perspective is described by Katz and Kahn (1966, p.71) as giving "primary attention to their internal structures." Scott (1978, p.275) describes the closed system approach as dealing "almost exclusively with the anatomy of formal organizations."

If anatomy characterizes the focus of closed systems approaches, then ecology characterizes open systems approaches. That is, the open system approach views an organization as a system of interrelated parts that are located both inside the organization and in the outside environment and that act upon one another so as to constantly change one another. Scott (1978, p.280), while recognizing that modern organization theory is not a singular "unified" system of thought, summarized it as asking four key questions:

1. What are the strategic parts of the system?
2. What is the nature of their mutual dependency?
3. What are the main processes in the system that link them together?
4. What are the goals sought by the system?

The elements of both approaches are discussed at length elsewhere (see for example Thompson, 1967; Aldrich, 1979; and Pugh et al., 1963) and indeed both perspectives have proven useful to understanding organizations, however, the essential difference between them is the fact that the closed-system approach views the organization as being essentially self contained and operating in an environment that is more or less static (or at least assumed to be a constant). The open-system approach, on the other hand, views the environment as a constantly changing and interactive source of uncertainty that must at least elicit some adaptive reaction for the successful continued operation of the organization.

Perrow (1972) asserts that the opposition (or perhaps the apposition) of these perspectives has more or less

forced the development of a "systems" perspective where, in its simplest form, "everything is related to everything else" (p.320). Presumably, this would include the operating environment of the continuing care retirement community.

The use of the concept "environment" as an analytical tool in understanding organizations is not a new development. Indeed, Hall asserts that even Weber's classic work

suggests that environmental conditions were no less important in the period following the Protestant Reformation than they are today. (1982, p.219)

Hall also asserts that some of the early organizational work by Selznick (1949, 1952), Gusfield (1955), and Janowitz (1960) are studies of environmental impact.

The "discovery," or perhaps the "rediscovery," of the environment by organizational researchers had the immediate impact of making an already complex situation even more complicated. In the early formulations of the open-systems approach (Barnard, 1938; Clark, 1956; and Lawrence and Lorsch, 1967) the environment represented an amorphous residual category consisting of everything that was not specifically within the organization. Indeed, a residual construction of the environmental component is found even in more recent works on the subject (Zey-Ferrell, 1979).

Among other things, this perspective introduced elements outside of the organization itself; elements over

which the organization had little or no real control. The difficulty was in focusing attention on those elements critically related to the operation--or indeed, even the survival of the organization--while avoiding the overwhelming complexity of the myriad minor elements which make up the environmental background, so to speak, of complex organizations and which have little individual impact on the focal organization.

Dill (1958) simplified the issue somewhat when he identified four types of "task environments" that should be considered in any organizational analysis. These four task environments--customers, suppliers, competitors, and regulatory groups--represent objects, in a conceptual sense, upon which the attention of the decision makers within any organization must be focused. In addition, they provide broad categories within which to understand organizational behaviors aimed at reducing uncertainty in the operating environment.

Environmental Uncertainty

The organizational literature is rich in environmental analyses relating to business firms and in some cases non-profit organizations such as hospitals and universities (Lawrence and Lorsch, 1967; Emery and Trist, 1965; Aldrich, 1979; Thompson, 1967; Meyer and Scott, 1983; Hage, 1980; Van de Ven and Ferry, 1980; Wilson, 1985; Zammuto, 1984; and Zeitz, 1983). These studies

almost always treat environmental uncertainty as a threatening, although inevitable, fact of everyday life. In fact, to some of the researchers, dealing with this uncertainty is not only an index of the successful operation of the organization, it is also the primary task to which all complex organizations must eventually return (March and Simon, 1958; and Roeber, 1973).

In their seminal work on the issue of organizational environments, Emery and Trist (1963) point out that the essential element of the relationship between the environment and the organization is the fact that each is changing and each has an impact on the other. Further, they assert that the "causal texture" of organizational environments consists of four interrelations that must be understood if a comprehensive understanding of the focal organization is to be accomplished.

These relationships are conceptualized as consisting of

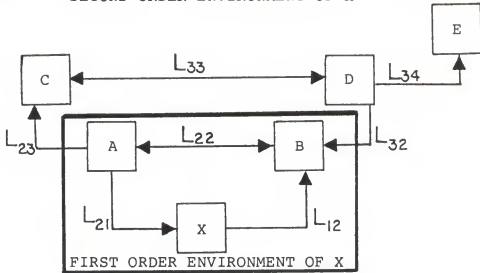
- a) Relationships among segments within the focal organization.
- b) Relationships between the focal organization and its suppliers and buyers and, (in the case of the continuing care retirement community) regulators.
- c) Relationships among the suppliers and buyers, and between those elements and other elements (organizations) in the environment
- d) Relationships between and among elements that have no direct contact with the focal organization but do have direct contact with elements having direct contact with the focal organization.

Further, in this model, elements of the environment in direct contact with the focal organization are labeled "first-order" environmental components, while those elements that have no direct contact are labeled "second-order" environmental elements.

It is obvious that the relationships in the model can be expanded to include other elements far removed from the focal organization. The extent and depth of the environment that is important to particular focal organizations is a matter for empirical determination. However, the point here is that this model will help in the development of a conceptual scheme for exploring the very complex and unstable environments within which continuing care retirement communities operate.

Figure 1 is a graphic illustration of the "causal texture" of organizational environments suggested by Emery and Trist. In this illustration the focal organization is represented by the letter "X" and other organizations in the operating environment of "X" are represented by the letters "A" through "E". In addition, organizations with which the focal organization has direct contact are located within what is labeled the "first order environment of "X". Organizations that do not have direct contact with "X" are located in what is labeled the "second order environment of "X".

SECOND ORDER ENVIRONMENT OF X



where

X = the focal organization.

A and B = organizations in direct contact with X.

C and D = organizations in direct contact with A and B,
but not with X.

E = organization in direct contact with C and D, but not
with A or B or X.

Emery and Trist (1963). (graphic presentation adapted
from: J. Stacy Adams, 1975, and cited in Miles, 1980).

Figure 1. Environmental Linkages

For simplicity, only first order and second order environmental elements are illustrated and only five other organizations are considered, but there is no empirical limitation on either the number of environmental orders or the number of organizations that can be analyzed. In fact, theoretically, all organizations could be represented at some environmental level of organization "X" simply because they are not a part of "X".

The Linkages, represented here by the letter "L" and appropriate subscripts, are indicators of possible interactions between the focal organization "X" and organizations in the operating environment of "X". Here,

linkages labeled L_{11} are interactions that take place entirely within organization "X". An example of this would be the transfer of a resident from independent living to nursing care within a continuing care retirement community.

The linkages labeled L_{12} and L_{21} represent direct contact between organization "X" and organizations in the first order environment of "X". Linkages L_{22} , on the other hand, represent interactions between organizations in the first order environment of "X" that do not directly involve "X".

Linkages L_{23} and L_{32} involve contact between organizations in the first order environment of "X" with organizations in the second order environment of "X". Finally, the L_{33} linkages represent interactions between organizations in the second order environment that do not directly involve any of the other organizations. Implied in this conceptual scheme is that as the subscript numbers become larger, control and predictability become more difficult with respect to organization "X".

Obviously this illustration could become very complex as the environmental order or the number of organizations considered is increased. However, intuitively, the impact of the first and second order environments is relatively so much greater than higher environmental orders that only these two will be considered here.

In terms of Figure 1, continuing care retirement communities must deal with a number of factors that are

essentially uncontrollable and that are quite outside their sphere of direct influence. For example, policy decisions by the Social Security Administration may have a profound impact on the operation of continuing care retirement communities, but may be instituted at a level far removed from the community itself (L_{33}). Thus, not only must the community formulate adequate responses to constantly changing but anticipated environmental demands, it must also attempt to anticipate what those demands might be in the future. In fact, the very survival of such communities may depend upon the ability of decision-makers to anticipate environmental changes and to effectively buffer the organization from changes when they do occur. Put simply, multiple level care retirement communities must plan today for service levels that will be required at an unspecified time in the future and which will be delivered within a changing regulatory context.

Because of the nature of the services delivered by continuing care retirement communities, both the demand for them and their costs are largely a matter of making educated guesses. The impact of incorrect estimates, regardless of the direction of error, can be quite damaging to the organization and its residents. One might reasonably conclude that the efforts of decision-makers in such communities are directed outward toward the environment in an attempt to gather as much information as possible about potential sources of turbulence, in order to lessen the uncertainty of the decision making process.

Quite apart from this intuitively attractive notion, Meyer and Rowan (1977); Meyer, Scott, and Deal (1981); and Scott (1981b), have suggested another reason that the attention of continuing care retirement communities should be focused on environmental elements. They have suggested that organizations may be divided into those that are "technological" and those that are "institutional" depending upon their purpose. Scott (1981b, p.342) has defined the difference as

The technical organization faces in toward its technical core and turns its back toward the environment; the institutional organization turns its back on its technical core to concentrate on conformity to its institutional environment.

Indirectly, these authors have suggested that health care institutions represent the institutional type, as it is used here. If this perspective is indeed applicable it suggests that continuing care retirement communities may have structural reasons for attempting to focus on their operating environments that make environmental analysis an important key to understanding them.

The effectiveness of a continuing care retirement community is, in many ways, easier to measure than the effectiveness of many business firms. This is due to the fact that the responsibilities and expectations of each party to the arrangement are clearly spelled out in the legal documents establishing the relationship. And, although the goals of the organization may indeed go beyond the stated goals, the legal documents provide a

minimum standard of operation. At this level of observation, the extent to which each party performs as stated in the agreement determines the effectiveness of the organization.

The view here, however, is that if we are to analyze continuing care retirement communities as a complex organizations and if the community itself is to be the unit of analysis, then the level of observation should go beyond a mere judgment of whether or not the legal agreement is being satisfied. Indeed, the residents themselves must be viewed as consumers and, thus, as a part of the operating environment. This implies that in order to understand the effectiveness of the organization, some attempt must be made to measure the qualitative elements of the operating environment.

Environmental Complexity

It is perhaps obvious that organizations, when rational, will seek to minimize the disruptive elements of their environment (Thompson 1967). It is equally obvious that although the two concepts are related, environmental uncertainty and environmental complexity are quite different phenomena. Intellectually, one can imagine very stable environments that are also very complex and simple environments that are highly volatile (Thompson, 1967; Miles, 1980; and Zey-Ferrell, 1979). The typology suggested by Dill (1958) provides a framework from which to categorize the important elements of the operating

environment of continuing care retirement communities. Similarly, Emery and Trist (1963) provide a theoretical framework from which the interrelations of these environmental components may be explored. Together, these provide a perspective that focuses attention on the important elements in the environment and suggests ways that these elements are related. However, neither specifically addresses the issue of environmental complexity.

Osborn and Hunt (1974) report that environmental complexity may be thought of as the "interaction" of dependency, risk, and relationships with other organizations. In the case of the continuing care retirement community, it is suggested here that regulation (in the sense of governmental regulation) plays a part that is at least as important as the other three in contributing to a complex operating environment.

Environmental Risk

Environmental risk has been a subject of some interest to organizational analysts (Lawrence and Lorsch, 1967; Terreberry, 1968; and Osborn and Hunt, 1974). These researchers report that risk is in some sense related to changes in the environment. That is, if an organization finds itself in a period of rapid environmental change, then there is greater risk that decisions may not produce the desired results. Obviously, the more rapid the rate of change, the less time there is available for gathering

information before the critical decision point is reached. However, risk may also be produced when the number of inputs related to the decision-making process is high. Thus a community operating in a relatively stable environment (low uncertainty) may experience high levels of risk based upon the number of factors that must be considered (high complexity) for any given set of decisions.

Environmental Dependency

Environmental dependency is another element of complexity. Again, the number of organizations or elements in the environment of the continuing care retirement community is not necessarily related to environmental uncertainty. But the potential for uncertainty in one organization, upon which the focal organization is dependent, requires that the focal organization scan a larger (i.e., more complex) environment than would be the case if dependency were not an issue. Thus, continuing care retirement communities must pay close and simultaneous attention to changes in their own operating environment as well as those of the organizations upon which they are dependent.

Regulation

Regulation is an important element of environmental complexity. One would expect a more complex operating environment for those organizations with more stringent

regulatory imperatives. The nature of continuing care retirement communities is such that regulatory agencies represent a major source of complexity and uncertainty as well. The fact that health care is provided to elderly residents means that, in addition to state and local regulation, federal regulation is likely as well.

Summary

The modern retirement community developed out of early efforts, on the part of religious and fraternal organizations, to provide a retirement residence for their elderly members. Although many of these prototypical communities are still in operation, they have changed in significant ways to meet the demands of the present population of elderly people.

The decade of the 1960s was marked by the growth of proprietary, as opposed to non-profit, communities. Along with private development came an emphasis on the lifestyle elements of these communities. There are two basic types of modern retirement communities; those that emphasize leisure and recreation aspects, and those that place emphasis on related support services. Although the former are important in understanding the housing alternatives of the elderly, this study specifically deals with only the latter.

Gerontological research into housing arrangements has generally focused on two issues; the issue of age segregation and the issue of resident satisfaction. While

these two perspectives are undeniably important, they tend to overlook the fact that retirement communities have a "personality" much like any business firm, and they have a life of their own, so to speak, that is quite separate from the resident population they attempt to serve.

For these reasons, it is suggested that an organizational approach to the study of continuing care retirement communities can provide much needed information about the organizations underlying the lifestyles found in these communities. This approach is in no way intended to replace the important research on the residents and the social desirability of such communities. Rather, it is intended to provide supplementary information about one aspect of these complex phenomena that has been largely overlooked.

Generally, there are two theoretical perspectives from which organizational research may proceed. These have been called the closed-system approach and the open-system approach. The difference is simply that the open-system approach takes account of environmental elements and focuses on the relationship of the organization to its operating environment, while the closed-system approach views the organization as essentially self-contained and focuses on the relationships within the structure.

The special nature of the relationships between continuing care retirement communities, both regulatory and otherwise, and elements in their operating environments, suggests that the open-system approach is necessary to further understanding.

CHAPTER THREE CONCEPTUAL FRAMEWORK

The conceptual framework for this dissertation combines elements from the widely diverse disciplines of social gerontology and organizational sociology. Continuing care retirement communities represent, at the same time, positions along a conceptualized continuum of care for elderly people, alluded to before, and a business enterprise designed to provide specialized services to a well defined target population. As businesses, they are also organizations that are designed to meet the needs of their officers and employees. And, as businesses, they have a profound impact on their surrounding geographic areas as well.

There are two vitally important definitions that must be considered before any study of this type can be undertaken: first, what is meant by the term organization; and second, what is meant by the term continuing care retirement community community?

Organization: A Definition

The term organization has been used to describe a wide variety of phenomena in recent years and its meaning has been somewhat eroded. Hall (1982) attributes some of

the confusion to the fact that "organization" as a defining term is often used for the more general term "social organization." While it is true that the two are linked, the term organization should be reserved for a specific type of collective action.

In one of the more popular definitions Aldrich (1979, p.4) suggests that organizations be defined simply as "goal directed, boundary maintaining, activity systems." While this definition is certainly succinct, it is overly inclusive and tends to oversimplify the impact of the environmental element. Miles suggested that organizations be defined as

. . . a coalition of interest groups, sharing a common resource base, paying homage to a common mission, and depending upon a larger context for its legitimacy. (1980, p.4)

Here too, although the "larger context" is taken into account, still the richness of the interplay between the operating environment and the focal organization is oversimplified.

It should be noted here that not all who study organizations are of the opinion that the term is in need of a specific definition. March and Simon (1958, p.1) appear to believe that defining the term organization adds little to the understanding of organizations. Hall (1982, p.28) counters with the assertion that

. . . a more reasonable approach would appear to be that definitions provide a basis for understanding the phenomena to be studied.

Given Hall's belief in the efficacy of defining organizations, it is not surprising that he himself has

offered one of the better definitions, and the one that will be used here. Hall defines an organization as

. . . a collectivity with a relatively identifiable boundary, a normative order, ranks of authority, communications systems, and membership coordinating systems; this collectivity exists on a relatively continuous basis in an environment and engages in activities that are usually related to a set of goals. (1982, p.33)

Here, Hall has identified what are the essential structural elements of organization and at the same time acknowledged the existence of environmental and temporal aspects.

In addition, Hall has provided a convenient framework from which to understand continuing care retirement communities as complex organizations. Implied in his definition are two questions which should guide organizational research: where are the organizational boundaries and how are they established; and, what are the internal systems that operate such that the overall survival of the organizations is achieved?

Continuing Care Retirement Communities: A Definition

As alluded to in Chapter One, there is little agreement even among gerontologists as to the precise differences between the terms "life care" and "continuing care" when referring to living arrangements for the elderly. In Chapter One, it was suggested that one useful solution to the problem would be to reserve the term "life care" for only those facilities where residents are

required to pay an entrance or endowment fee, and who, in return, are given a guarantee of life long care.

"Continuing care", on the other hand, is viewed as a broader term encompassing a range of living arrangements including life care communities. The only definitional requirement for the term "continuing care" should be that there exist a reasonable expectation that life long care will be available to the residents regardless of the existence of an actual contractual agreement to provide those services. Thus, "life care" is a special case of the broader category of housing referred to here as "continuing care retirement communities."

Powell and MacMurtrie (1986, p. 234) do not make the distinction between "continuing care" and "life care" made here, however, in their discussion of what they call continuing care retirement communities (CCRCs), they identify three characteristics that are unique to this type of living arrangement:

The physical plant consists of independent living units and generally has one or more of the following facilities: congregate living, personal care, intermediate nursing care, and skilled nursing care.

The community guarantees housing and access to various health-care services under a contract with the residents that lasts for more than one year.

The additional fees for resident health care, if any, are less than the full costs of such services, implying an insurance approach to finance the health-care costs of contract holders.

In the present study, all of the communities included meet the three criteria developed by Powell and MacMurtrie and all of them are continuing care retirement communities using the definitional distinction suggested in Chapter One. While some of them offer contracts guaranteeing health care for the life of the residents and could thus be called life care communities, almost all of them require entrance fees and thus fit into the broader category.

The State of Florida defines a "continuing care facility" as one that

. . . furnish(es), pursuant to an agreement, shelter, food, and either nursing care or personal services . . . whether such nursing care or personal services are provided in the facility or in another setting designated by the agreement for continuing care, to an individual not related by consanguinity or affinity to the provider furnishing such care, upon payment of an entrance fee. (Florida Code, 651.011, 1984)

The State of Florida's definition of continuing care is perhaps more inclusive than the one developed by Powell and MacMurtrie (1986) discussed above in that it makes no distinction as to how the services provided to the residents are financed or how long the contract is to be in force. In fact, the Florida statute specifically states that agreements to provide continuing care include agreements to provide care for any duration and include agreements that are terminable by either party involved. However, the two definitions are substantially in agreement that a continuing care facility offers some form

of personal service to the resident population under the terms of a mutually binding agreement between the resident and the provider.

The Continuum of Care

Another conceptually important perspective from which to consider continuing care retirement communities is to view them as one set of alternatives among several, all of which can be placed along a continuum from least supportive to most supportive, or in terms of health care, from independent living to institutional living.

Atchley (1980) and Atchley and Miller (1975) have developed one popular view of the so-called continuum of care that identifies two main categories of living arrangement and five sub-categories based upon the levels of support required by the individual residents. Table 1 is an adaptation of that view.

In this conceptualization, those living arrangements labeled "independent," range from the traditional single family house to housing where supportive services, such as "meals on wheels" and homemaker services, are provided. Those arrangements labeled "group housing" include living arrangements where some supportive services are provided, usually in a common area, to living arrangements in full care nursing homes. In addition, there is an area between these main categories where the distinctions between semi-independent housing and group housing become blurred.

Table 1
The Continuum of Care.

Housing Type:	Significant Criteria:
INDEPENDENT:	
Fully Independent	Self-contained, self-sufficient household. Residents do 90% or more of the cooking and household chores.
Semi-independent	Self-contained but not entirely self-sufficient. May require some assistance with cooking and household chores.
GROUP HOUSING:	
Congregate Housing	Can still be self contained, but less self-sufficient. Cooking and household tasks are often incorporated into housing unit.
Personal Care Home	Neither self contained nor self sufficient. Help given in getting about, personal care, grooming, and so forth, in addition to cooking and household tasks.
Nursing Home	Neither self contained nor self-sufficient. Total care, including health, personal, and household functions.

Source: Adapted from Atchley, 1980, p.320.

In their study of shared housing, Streib, Folts, and Hilker (1984) presented a graphic presentation of the continuum of living arrangements based upon Mangum's conceptualization (1979). That graphic presentation is reproduced in Figure 2.

Least Supportive	Housing Type:	Most Supportive
	Nursing Homes	
	Life Care Facilities	
	Board and Care Homes	
	Shared Living Homes	
	Retirement Hotels	
	Retirement Apartments	
	Retirement Villages	
	Mobile Home Parks	
Apartments		
Condominiums		
Houses		

Figure 2. Continuum of Living Arrangements: From Private Home to Nursing Home
Source: Adapted from Mangum, 1979.

In this view each of the types of living arrangement in the graph represents a point on a line from independent living in houses to dependent living in nursing homes. This graph is not intended to suggest a linear progression, rather, an additive progression is suggested where each successive stage represents a more supportive environment than the one before it and in a sense the services of the lower arrangement are encompassed in the higher ones.

The break between the first three categories and the final eight categories is intended to convey a belief that there is a fundamental difference between the non-supportive traditional living arrangements on the left of the graph and those that offer supportive services represented on the right side of the graph. Indeed, those arrangements on the right side of the graph were developed specifically because there was a large group of elderly people who, for a variety of reasons, found that traditional living arrangements failed to adequately address their needs.

For whatever reason, the fact is that supportive, non-traditional living arrangements are meeting the housing needs of a small but practically significant portion of the elderly population. Streib, Folts, and Hilker (1984) have estimated that between 10% and 20% of the elderly population lives in non-traditional housing such as that depicted on the right side of Figure 2. If that estimate is accurate, it would mean, based upon the 1984 population estimates of the Bureau of the Census, that between 2.8 million and 5.6 million people choose to live in supportive care environments.

Continuing Care and the Continuum of Care

This study includes a type of living arrangement that, in terms of Figure 2, would be located somewhere after, that is higher and more to the right of, Board and Care Homes. The difficulty in precisely placing continuing

care facilities on any continuum is that such living arrangements not only encompass a wide range of supportive services intended to prevent institutionalization, but at the very same time they encompass a wide range of health care services that include total institutionalization. For that reason it is difficult to make the conceptual distinction between continuing care facilities that offer nursing care and stand-alone nursing facilities.

The two are, however, quite different. The main difference is that the stand-alone institutional nursing home, here represented as the most supportive environment (although a case could be made for the acute care medical hospital being the most supportive environment), offers only health related support services to individuals who are already unable to care for themselves. Little practical distinction is made among residents regardless of functional ability.

The continuing care facility is, on the other hand, designed to provide a variety of support services in an environment that takes into account differences in ability to care for oneself, and emphasizes those activities that residents can still perform. Rather than the norm, constant nursing home institutionalization is viewed as a last resort to be provided only after all other alternatives, within the continuing care context, have been exhausted.

Thus, while the institutional nursing home resident becomes more and more dependent upon the institution for

his or her day-to-day life, the continuing care resident becomes more and more dependent upon a wide variety of services aimed at avoiding institutionalization while at the same time recognizing that institutionalization is available after all other alternatives become insufficient to sustain day-to-day activities. This is a major difference the impact of which should not be lost in the intellectual exercise of constructing a continuum of care.

Whether the array of living arrangements currently available to elderly individuals is viewed as a continuum based upon the quality and/or quantity of services offered, or as a discrete collection of services that is related only by the fact that they are intended to establish alternative living arrangements is, in the final analysis, one of personal preference. The view suggested here is that there is indeed an additive (although not linear) continuum of living arrangements and that it can be graphically presented in such a way that the differences between continuing care and institutional care can be taken into account.

Figure 3 is a restatement of the continuum of living arrangements found in Figure 2 taking into account the differences discussed above.

The most striking difference here is the addition of two more breaks in the continuum. Notice that here continuing care facilities are represented as a separate

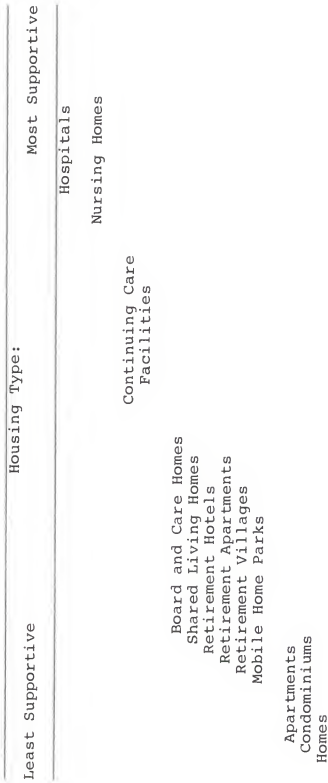


Figure 3. Continuum of Living Arrangements
Source: Adapted from Streib, Folts, And Hilker, 1984.

category more supportive than board and care homes or shared living arrangements, but less supportive than nursing homes or acute care hospitals. Notice too that stand-alone nursing homes and hospitals are represented here as a separate category and make up the most supportive group of living arrangements.

There is, both in reality and in this conceptualization, an overlap between the living arrangements located at or near the breaks. Since it is not being suggested that any sort of linear continuum exists, the overlap is not particularly problematic. Still, the differences between apartment living and living in a trailer park or retirement village can, depending upon the individual and the particular park or village, be subtle indeed. So too, it can be difficult to distinguish between the most supportive board and care homes and the least supportive continuing care facilities.

Perhaps this difficulty is best illustrated by the break between nursing homes and continuing care facilities. Here, it is obvious that the most supportive level of care in the most supportive continuing care facility is not only structurally indistinguishable from the services offered by most stand-alone nursing homes, but oftentimes the nursing home component of a continuing care facility is open to the general public and, to the public at least, it is, in all meaningful aspects, a stand-alone nursing home.

It is clear that state regulatory agencies treat the nursing home components of continuing care communities very much the same as they do all nursing homes. In licensing, in certification of need, and in inspection, there are few regulatory differences between nursing homes operated as part of a continuing care community and nursing homes operated as stand-alone institutions. In fact, the procedures for licensing a nursing home are similar regardless of whatever other support services the sponsors or investors intend to provide.

As if the blurring of the points along the continuum of care were not confusing enough, it should also be considered that along with subtle variations between the various categories of living arrangements, depicted in Figure 2 and Figure 3 as discrete points, there are also variations within each of the categories themselves. Not all facilities licensed as continuing care facilities are licensed to operate a nursing home component. And, although the underlying foundation of all shared living arrangements is the provision of a supportive environment, there is wide variation in both the quality and the quantity of services provided (See Streib, Folts, and Hilker; 1984).

Fortunately for the present research, that the lines between the breaks in this conceptualization of a continuum of care are not clearly drawn is not especially problematic because the state regulatory mechanism has

determined that continuing care facilities represent a special category for the purposes of licensure, and all facilities in the State of Florida that meet the rather loose definition found in the state code, discussed earlier, are licensed as continuing care facilities. And, more importantly, this is true irrespective of whether a nursing facility is present or not.

Continuing Care Retirement Communities
and the Open Systems Approach

The open-systems approach to organizational analysis is not a full-blown theory in the sociological sense of the phrase. Rather, it is a conceptual framework, or set of "theoretical concepts" (Hage, 1972) designed to guide research in the direction of important variables and to

. . . isolate features of the world that are considered, for the moment at hand, important.
(Turner and Beeghley, 1981, p.2)

The essence of the open-systems approach is that it forces the researcher to consider the impact of influences outside the organization under study. These influences are conveniently subsumed under the residual classification "environment."

In addition to isolating important features, the open-systems approach requires that the organization and its operating environment be viewed as a system of interrelated parts each contributing to the operation of the organization in a constantly changing compromise between the requirements of the organization and the demands of the environment.

Adoption of the open-systems approach for this study of continuing care retirement communities, assumes that the operating or "task" environments for these facilities is an important element in their continued operation. That this is indeed the case can be inferred from the fact that the typical continuing care retirement community must successfully carry on a more or less continuous and simultaneous organizational relationship with: federal, state, county, and municipal regulatory agencies; vendors of food, medical supplies, office supplies, equipment, building materials, and other supplies necessary for day-to-day operation; employee unions; resident's associations; organizations that maintain equipment and the physical plant; and relatives of the residents.

The organizational uncertainty created by this environmental mix is an empirically verifiable phenomenon that this study will attempt to address. However, it is clear that the content of the task environment is indeed a complex one. This of course implies that at least some organizational effort must be diverted from the actual provision of services to the equally important task of ordering and dealing with environmental influences. If this were not the case then the administration of continuing care retirement communities would be reduced to the simple matter of coordinating service delivery.

A study of continuing care retirement communities that incorporates organizational analysis, which was after

all developed largely through research in the field of economics, has one further important implication. It implies that continuing care retirement communities have at least a dual organizational personality. On the one hand such communities are aimed at providing personal, health, and housing services to a specified group of elderly residents and, as such, they are likely to espouse humanistic goals that are less business-like than they are need oriented. On the other hand, these communities are in a very real sense business organizations that must pay close attention to economic concerns and business dealings if they are to survive and continue to provide the services that they believe to be important.

Continuing Care Facilities as Business Organizations

As a business enterprise, continuing care retirement communities are similar to other business firms involved in the delivery of services to a specialized population of consumers. Most organizations attempt to convert a limited resource pool into a product, in this case a marketable package of services, that will meet the needs of a target consumer population and at the same time meet the needs of the members of the organization providing those services.

In oversimplified economic terms, the continuing care retirement community can be viewed as a collection of interacting elements bifurcated into "providers" and "consumers." The actual services that are delivered, that

is the contents of the market package, are determined by an interactive process that involves both the consumer and the provider such that the final product reflects a compromise between what the consumers want and what the organization can provide.

This interaction takes place within the context of the consumer's desire to obtain as much service as possible, and the provider's desire to meet expenses. In actuality, the process is much more complicated than this because quantity of service, as it refers to the range of services available, is not the ultimate goal of the resident. Since, if we assume a rational population, the resident's goal is to remain outside the institutional setting as long as is possible, and since that is a direct function of the quality of non-institutional services available, quality of service is probably more important than the quantity of service, at least in this context.

The other side of the compromise is equally complex. To simply say that the continuing care retirement community attempts to provide a marketable package of services to a target population and at the same time meet expenses is to deny the motives underlying the establishment of these facilities.

It is a fact that almost all of these facilities are non-profit corporations. Powell and MacMurtrie (1986) reported that fully 98% of the facilities meeting their operational definition were organized as non-profit

corporations and that a "substantial percentage have some type of religious affiliation" (p.235). However, the fact that the corporate image is non-profit and, ostensibly at least, is not so much concerned with anything beyond meeting the expenses of the services offered tends to obscure the more personal motives involved in the establishment of such a facility.

To be sure, service to elderly people is an important, if sometimes over-stated motive for the establishment of continuing care retirement communities. However, the fact remains that such communities provide relatively stable employment and, therefore, income to those who provide the services. In this context then, the overall interactive compromise upon which organizational decisions are based is not so much one between providing all the services that can be financed at a given level of organizational income, but rather it is a compromise between providing ever higher levels or intensity of services, and meeting the ever increasing income needs of the providers of those services.

To the extent that these facilities, and indeed probably all non-profit service organizations, are successful in this effort, the organizations involved will increase their chances for survival. And, as the work of Berle and Means (1968) implies, survival of the organizational structure may be the ultimate goal to which all organizations aspire.

Where the continuing care retirement community differs from the typical business enterprise, is in the nature of its product. The fact that these communities are established to provide a living environment for a group of elderly people means that the residents, as a group, have extraordinary power with respect to the organization. In few other instances are consumers so completely involved in decisions affecting the services offered by a business organization.

This phenomenon was identified by Streib, La Greca, and Folts (1984) in their study of retirement communities. They noted that even in communities where the differences between the residents and the owners were clearly established, the residents still had great influence on those responsible for decision-making. In some cases, where the residents and the organization disagreed on an issue, the resident's preference prevailed.

Because of the legal and financial relationship that exists between the resident and the organization, the boundaries of just what is within the organization become less distinct. This is not necessarily a problem in the case of the continuing care retirement community, but the potential for difficulty remains.

Put another way, when the organizational boundaries of continuing care retirement communities, with respect to the residents, are not clearly defined it is difficult to make decisions, ostensibly rational ones, relating to the

operation of the facility without first defining the appropriate boundary through negotiation with the residents. In time, boundary definition may become an end in itself that must be reconsidered each time a decision is made. This inability to judge in advance and with certainty all sources of relevant influence can be subsumed under the more general term: boundary control.

Organizational Boundary Control

Aldrich (1979), in his work on organizational environments, has stated his belief that control of the environmental boundary is a critical problem for many organizations.

The inability (of organizations) to control their boundaries leads to variation, as organizations are opened to external influence and authorities seek means of closing vulnerable segments and coping with heterogeneous and varying demands from clients, members, and others. Boundary control is a defining characteristic of organizational forms, and variations in forms can be related to varying environmental conditions. (p. 219-220)

The multi-level care retirement community has two distinct problems relating to control of its boundary. First, as discussed above, there is the constant redefinition of boundaries when dealing with the residents. Second, there is the fact that other environmental elements must be dealt with and although the problem is less complicated, these too require boundary definition.

Essentially, the fundamental question for multi-level care retirement communities is not how to maintain their boundaries, although that is an important issue, but rather the fundamental question is how to define the boundaries. The approach to this question, it will be suggested, is that they define the organizational boundaries based primarily upon which element of the environment is being considered. Thus, in normal business dealings, one set of definitions is applied and in issues relating to the residents another altogether different set of organizational boundaries is understood to exist.

Part of the problem of boundary control is the fact that continuing care retirement communities have a dual personality that is part business and part care-giver. And, irrespective of the criteria used to judge impact, the residents represent an important and influential element of both. As a business, decisions must be based upon the financial impact of the possible outcomes, that is, they must take into account what is "best" for the organization. Similarly, as care-givers, decisions must be based upon what is "best" for those receiving the services.

Although these two considerations are not entirely antithetical, and in fact may at times coincide such that what is "best" for the organization is also "best" for the residents, they suggest the basis for two separate boundary control mechanisms; one that is applied to

business decisions and that treats the residents as an element of the environment, and another that is related to the humanistic motives and goals of the community and that treats the residents as members of the organization.

The assertion that multi-level care retirement communities exhibit multiple boundary definitions based upon specific environmental elements implies a multiple organizational, for lack of a better term, "personality." Thus, this type of organization changes its boundaries to meet the demands of the particular environmental element that requires attention and, in so doing, rearranges its organizational elements.

Admittedly this is an oversimplification because many environmental elements demand attention simultaneously. The point is that as an organization, multi-level care retirement communities exhibit somewhat flexible boundaries in response to variable environmental demands.

The Structural Elements of Continuing Care Retirement Communities

Organizational analysis has identified several structural concepts that offer a framework for a better understanding of complex organizations. The important structural elements to this study of continuing care retirement communities are complexity, formalization, and centralization.

Complexity

In its simplest terms complexity is a concept that refers to the number of structural units into which an organization is divided. According to Zey-Ferrell (1979, p. 169) these units or divisions may be based on a number of criteria including "roles, positions, knowledge, functions, rank, and so forth." Blau and Schoenherr (1971, p.302) take complexity to mean "the number of structural components that are formally distinguished." In a similar definition Price and Mueller (1986, p.100) define complexity as the "degree of formal structural differentiation within an organization."

The literature in organization studies is rich in definitions of the term complexity. Generally, however, two important issues seem to dominate. First, the whole idea of complexity revolves around the number of divisions in a particular organization, irrespective of the criteria used to divide the organization. Second, the divisions are usually required to be formally established and based upon formal criteria. Hall (1982, pp.78-83) further suggests that there are three elements to organizational complexity; horizontal differentiation, vertical differentiation, and spatial dispersion.

Horizontal differentiation refers to the number of different positions at any given level in an organization. It is an indication of the lateral dispersion and, indirectly, of the complexity of the technology employed to achieve whatever tasks the organization has set for itself.

In the case of the continuing care retirement community, lateral dispersion can be one indicator of the extent of services delivered to the resident population. That is, if nothing else is known about a particular community, one with little horizontal differentiation must either be so small, in terms of population, that a variety of services can be offered with little specialization, or it must offer fewer services than other communities with higher levels of lateral dispersion.

Vertical differentiation, also called "hierarchical differentiation" by Hall (p.81), is the number of levels in an organization. Pugh, Hickson, Hinnings, and Turner (1968) have suggested that one simple way to view vertical differentiation is to look at the number of different positions between the highest ranking individual and the lowest ranking individual.

One perspective that is particularly useful is one developed by Hall, Haas, and Johnson (1967, p. 906). Table 2 indicates, in outline form, just what indicators can be used to determine the complexity of organizations.

Table 2
Indicators of Complexity in Complex Organizations.

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1. Lateral Differentiation (General)
 - The Number of Distinct Organizational Goals.
 - The Number of Organizational Activities.
 2. Lateral Differentiation (Specific)
 - The Number of Divisions or Departments.
 - The Number of Subdivisions Within Departments.
 3. Vertical (Hierarchical) Differentiation
 - Number of Levels.
-

Source: Adapted from Hall, Haas, and Johnson, 1967.

Hall (1982) points out that most researchers make the assumption that authority follows the vertical path upward. Put simply, the higher the position on the vertical plane in an organizational chart, the greater the authority. Hall also points out that this is not always the case, referring to specific situations where anomalous relationships appear between authority and position.

It is likely that such anomalies exist in continuing care retirement communities because of the nature of the services offered. For example, because both business and medical decisions must be made in the day-to-day operation of these facilities, a situation might arise where a division head has the position to make a certain decision concerning his or her division but not the authority. One area where this might be a common occurrence is where business decisions are made that have an impact on delivery of medical services.

Formalization

Formalization is easy enough to define. It is however, difficult to attach a generalized substantive meaning to the term, since it attempts to describe such a broad concept. Price and Mueller (1986) in a synthesis of the definitions of Hall (1982) and Scott (1981a) defines formalization as

. . . the degree to which the norms of an organization are explicitly formulated. (p. 137)

Presumably, this would include such things as written job descriptions, methods, and procedures as well as

operating "philosophies" and goals, to the extent that these are written and well defined.

Again, Hall, Haas, and Johnson (1967, p.907) have developed a set of indicators of formalization. These have been adapted for the present study and are presented, in outline form, in Table 3.

Table 3
Indicators of Formalization in Complex Organizations.

1. Roles:

The Degree to which the Positions in the Organization are Concretely Defined.

The Presence of Absence of Written Job Descriptions.

2. Authority Relations:

The Degree to Which the Authority Structure is Formalized.

The Extent to Which the Authority Structure is Formalized in Writing.

3. Communications:

The Degree of Emphasis on Written Communications.

The Degree of Emphasis on Established Channels of Communication.

4. Norms and Sanctions:

The Number of Written Rules and Policies.

The Degree to Which Penalties for Rule Violations are Clearly Stipulated and Codified in Writing.

5. Procedures:

The Degree of Formalization of Orientation and Training Programs for New Members.

Source: Adapted from Hall, Haas, and Johnson, 1967.

In the special case of continuing care retirement communities, formalization could be an important indicator of the state of the environment. If the environmental influences are particularly volatile, it would seem reasonable to assume that a highly flexible organization would be better suited to deal with it than one that has a ridged approach. And, flexibility would seem to be inversely related to formalization. Put simply, written procedures are not likely to provide adequate responses to a highly diverse and rapidly changing set of environmental demands.

Centralization

The essential characteristic of centralization can be simply described by the question: who makes the decisions? To the extent that decision-making is concentrated in a single, or a few, positions within the organization, the organization can be said to be centralized. Van de Ven and Ferry (1980, p.399) define centralization as

The locus of decision making authority within an organization. When most decisions are made hierarchically, an organizational unit is considered to be centralized; a decentralized unit generally implies that the major source of decision making has been delegated . . . to subordinate personnel.

As an indicator of the distribution of power within an organization, centralization is, as Hall (1982) has pointed out, one of the best ways to summarize the structural character of an organization. Although structural differentiation and power centralization are by

no means the same concept, they are closely related. And, this close relationship means that much can be learned about the structural differentiation of an organization by looking at its power centralization.

Melcher (1975) has developed a classification scheme that provides important insights into what is meant by centralization. That scheme is presented in Table 4.

The use of centralization as a tool for exploring the structural characteristics of an organization is especially important to studies of retirement communities, whether they offer continuing care or not, because it is often the case that, as Streib, La Greca, and Folts (1984) found, the people who occupy the formal positions in the hierarchy are often not the people who make the day-to-day operating decisions.

Given the non-profit status and the humanistic predisposition of most continuing care retirement communities, it is entirely reasonable to expect that in some cases the locus of decision-making power does not follow the formal hierarchical scheme. By examining the power centralization within a continuing care retirement community, a better understanding of its structural properties may be gained, even when the structural characteristics are quite different from the formal organizational chart.

Table 4. Forms of Centralization.

Policies, Procedures and Rules		
Hierarchical Level	Few/Broadly Defined	Many/Narrowly Defined
TOP LEVEL	<p>AUTOCRACY</p> <p>High centralization: Few decisions made by lower level personnel.</p>	<p>BUREAUCRACY CENTRALIZED</p> <p>Centralized: Decisions made by lower level personnel are governed by formal procedures and rules. Other decisions are referred to higher level personnel.</p>
BOTTOM LEVEL	<p>COLLEGIAL</p> <p>Highly Decentralized: Most decisions made at lower levels without policy restrictions. Other decisions follow formal policies.</p>	<p>BUREAUCRACY DECENTRALIZED</p> <p>Decentralized: Most decisions made within policy framework. Other decisions not covered by policy are at the discretion of personnel.</p>

Source: Adapted from Melcher, 1975.

Autonomy and Power in Continuing Care
Retirement Communities

There are two final concepts that are important to the study of continuing care retirement communities. They are the concepts of autonomy and power. And, while these two ideas are related there are subtle differences between them that require elaboration

In their study of retirement communities, Streib, La Greca, and Folts (1984, p.403) defined autonomy as

the determination of goals, policies, and operations of the local (retirement) community and its units by local people rather than outsiders.

The central idea of autonomy, first elaborated by Warren (1970, p. 219), as it applies to the present case, is that a retirement community is autonomous to the extent that it is able to determine its own destiny. In the context of this study, autonomy is operationally defined as the extent to which one organization, in this case a continuing care retirement community, "has power with respect to its environment" (Price and Mueller, 1986, p.40).

Power, on the other hand, is the ability of one organization to influence the operation of another organization, here any organization located in the operating environment of the focal organization.

A convenient way to consider these concepts, and the way that will be suggested here, is to view each as a different perspective on the same basic phenomenon. Thus,

power is nothing more than an assessment of environmental autonomy looked at from within the focal organization, and autonomy is nothing more than organizational power viewed from the environment. Autonomy implies, metaphorically at least, standing at the center of the focal organization and looking outward to assess the influence of the environment. Similarly, power metaphorically implies standing somewhere in the environment and assessing the influence of the focal organization. Thus both concepts are assessments of the relative strength of the focal organization and the environment.

Summary

In order to gain a clearer picture of continuing care retirement communities, this study combines elements from the disciplines of gerontology and organizational sociology. This in itself implies that these communities are complex organizations whose goals and impact go quite beyond the mere delivery of housing and health care services to self-selected elderly people.

Popular in the gerontological literature is a conceptual model referred to as the "continuum of care." This model, in its most common usage, implies a set of housing alternatives from least supportive, or independent living, to most supportive, or supervised living. This study suggests that the model would be more useful to understanding if it is expanded to take account of two additional elements not generally considered. It is

suggested that the conceptual model of a continuum of care should include the living arrangements, the housing types, and the service types available in these communities.

It is further suggested in this study that, although the overwhelming majority of these communities are non-profit organizations, they behave, at one level, very much like other business organizations in the service industry. This aspect of continuing care retirement communities has been largely overlooked by recent research.

Two very important variables in understanding the relationship of these communities to their environments are power and autonomy. The relative positions of the communities and the elements of their environments in terms of power and autonomy in large part determine not only the organization-environment relationship, but they also have much to do with the amount of organizational effort that is required to successfully deal with the environment.

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CHAPTER FOUR METHODS AND DATA

This research combines several methods of data collection and analysis. Because so little information is available concerning the structural and environmental elements of continuing care retirement communities, a combination of face-to-face interviews, surveys, and content analysis of written documents was employed in an effort to broaden the search for relevant data. Particular attention was paid to documents produced from within several of the organizations themselves.

The results of this effort were highly successful in that, along with historical information, information related to the goals and philosophical underpinnings of these organizations was gleaned from the written documents. These important data could have been overlooked had only survey and interview techniques been utilized.

The quantitative data collected in this study were entered into a card image computer file and processed with the Statistical Analysis System (SAS). Frequency tables and the other summary techniques used here, were all generated by that computer analysis package.

Methods

The study of complex organizations may be divided into two broad methodological categories: case studies and comparative studies. The case study is typically thought of as an in-depth analysis of a single organization or organizational type (Baldrige, 1971). The comparative study, on the other hand, consists of somewhat more shallow data gathered from a larger number of sites (Blau, 1965). For convenience, and inasmuch as the former type is primarily descriptive in nature, one may think of the case study as a qualitative analysis of the elements of a specific organization and the comparative study as a quantitative analysis of the generalized elements of a type of organization.

The Case Study Method

According to Baldrige (1971), the case study method is particularly appropriate in several situations (the author actually lists four situations but only three are of special relevance here). When little information exists on the topic or when the research is of an exploratory nature, then the case study can generate valuable insights into the mechanisms by which an organization operates. Similarly, if change is important, it is necessary to view the details of operation and decision making.

One of the underlying assumptions of this study is that all of these conditions are germane to continuing care retirement communities. Specifically, as was noted in

the Introduction, several gerontologists (Netting and Unks, 1986; Winkelvoss and Powell, 1981; and Wasser and Cloud, 1980) have called attention to the fact that very little information is available concerning these types of living arrangements. Similarly, since there have been no studies of the organizational elements of continuing care retirement communities, this study is, by definition, exploratory. Finally, although the idea of change is a matter for empirical verification, the very fact that regulatory agencies have stepped up their efforts in the recent past implies that the operating environments of these facilities are indeed changing.

The case study method, by itself, does have certain inherent weaknesses that tend to diminish its usefulness. Zey-Ferrell (1979) asserts that by limiting analysis to one case, however rich the data may be, the results are case specific to the point of severely limiting the value of the findings.

Obviously, whatever general knowledge can be gained by the case study method is entirely dependent upon the extent to which the focal organization is more or less typical. Unfortunately, any research that employs the case study method exclusively, almost by definition, rules out any meaningful assessment of just how typical a particular organization happens to be. For that reason, data from other organizations is needed for any meaningful conclusions about a particular type of complex

organization. That other data is provided here by what can be called the comparative method.

The Comparative Method

One of the main proponents of the comparative method for the study of complex organizations is the sociologist Peter Blau. In one of his major works in the field of organizational research, he defines the comparative study of organizations as

The systematic comparison of a fairly large number of organizations in order to establish relationships between their characteristics. In short, the term is used here to refer to quantitative comparisons. (1965, p.323)

This method, according to Zey-Ferrell (1979), is especially suited to any analysis that places emphasis on the environmental elements of complex organizations.

The advantages of the comparative method are many and depend, at least in part, upon the underlying purposes of the research. The primary advantage however, is that by comparing a number of organizations, statements can be generalized and thus the elaboration of more or less typical characteristics of a general category of organization is facilitated. Also, comparative analysis allows the researcher to differentiate between broad categories of organizations based upon generalized characteristics that could be obscured by the type of data collected in the case study method.

Another of the advantages often cited in the literature is that because, in practice, the comparative

method involves relatively shallow data collected from a small group of people within many organizations, the overall costs of the research can be considerably less than if in-depth case study type data were collected. Incidentally, this in itself may be a major contributing factor to the recent tendency away from case studies and toward comparative analysis in organizational research.

Although the case study method was extensively employed in the early organizational research, recent efforts have been decidedly in the direction of the comparative method. This tendency would seem to imply that the vast variety of organizational types has been exhausted at least in terms of the in-depth case study. It is suggested here that the continuing care retirement community represents an as yet largely unexplored type of organization and that valuable information can be gained from an in-depth exploration of such communities.

However, even though the fact that continuing care retirement communities are largely unexplored research phenomena dictates a broader research technique than that implied by the comparative method alone, any attempts at standardizing or generalizing the concepts and operational features of this type of living arrangement requires more than a case-study approach.

Data Collection

Data collection was conducted in a three-stage effort that combined elements of both the case study method and

the comparative method. An in-depth case study of one continuing care retirement community located in a rural area of the State of Florida was followed by a similar but more focused case-study of one other community. The second community was located in an urban area of Florida. After preliminary analysis of the data from both sites, a questionnaire was developed and mailed to all facilities either already licensed or attempting to be licensed as continuing care communities in the State of Florida. In addition, questionnaires were administered to officials at the two case-study sites.

The case studies relied on face-to-face interviews with officials and employees at various levels in the hierarchies of these organizations, as well as content analysis of historical, promotional, and legal documents that were made available by the officials. In addition, current data about the characteristics of the resident population was analyzed along with whatever tabulations the facilities normally keep with regard to the residents. In all, fifteen face-to-face interviews were conducted at the rural site and an additional seven were conducted at the urban site.

However, because of concerns over confidentiality and the fact that informed consent was neither requested nor obtained from any of the residents in these facilities, no personal information was sought concerning either the financial or the health status of individual residents.

The data concerning the residents are summary data that were compiled entirely by the officials of the various facilities and made available by them.

The questionnaire used in the survey was developed after a preliminary analysis of the case study data and consisted of forced-choice and short-answer open-end questions in a self administered format. The questionnaire is reproduced in Appendix A. Because information about the fee structures and the organizational arrangements of these communities was vital, respondents were asked to include these data when they returned the questionnaire.

Questionnaires were mailed to individuals listed as "contact persons" on the application for licensure. The State of Florida maintains two separate lists of continuing care retirement communities. First, there is a list of fully licensed facilities that consists only of facilities actually in operation. The second list consists of facilities that have applied for licensure but that have yet to show compliance with one or more of the provisions of the Florida regulatory statutes. In general, the facilities that are "provisionally licensed" have not yet begun operation.

Florida's regulatory statutes require that fifty percent of the units in a planned continuing care retirement community be reserved by potential residents before a certificate of authority is issued. As it is defined in the statutes, the term "reserved" means that

ten percent of the required entrance fee has been paid to the community by a potential resident. Most of the facilities on the "provisional" list have met all of the other statutory requirements and are in the process of attempting to meet the fifty percent reservation requirement.

At the time of this study, there were sixty-three fully licensed continuing care retirement communities operating in the State of Florida, with an additional thirty-two listed as provisional. Although it was recognized from the beginning that many of the facilities on the provisional list would never begin operation, questionnaires were mailed to each of them in order to broaden the base from which the data were collected.

One interesting outcome of this attempt to contact the provisionally licensed facilities was the discovery that many of the sponsors and investors had abandoned plans to build a continuing care retirement community because they could not obtain the needed fifty percent reservation level. Several, where actual construction had already begun, reported that the original plan had been modified such that the facility would begin operation as a simple apartment or condominium arrangement with little in the way of services.

Some of these developers also reported that they had not entirely abandoned the continuing care idea and that if, sometime in the future, it was determined that such a

facility would be feasible, they would then convert the existing facility to that purpose. Unfortunately, the pursuit of this line of inquiry is beyond the scope of the present research, but it suggests itself as a rich area for future effort.

The primary purpose of the survey instrument was to develop an "organizational profile" (Pugh et. al., 1963) of continuing care retirement communities in the State of Florida as well as at least a summary statement about the characteristics of those who choose to live in them. Although the analysis is limited to facilities located in the State of Florida, questionnaire data were obtained from six other facilities operating outside the State of Florida. These data, not a part of the original plan of research and obtained quite fortuitously, were used as corroborative evidence but were not included in any of the summary calculations.

Phase I: The Case Study Research Settings

Pine View Village

The site selected for the case study phase of this research is a small continuing care retirement community located in a rural county in Northwestern Florida. In order to protect the confidentiality of those who so freely participated in this study, the community will be given the pseudonym "Pine View Village."

Pine View Village was selected for several reasons. Primarily, the site was selected because it has an

extraordinarily long and well documented history of providing housing services to various target populations at different times. The fact that its transition into a continuing care retirement community was a conscious and planned organizational shift in both goals and purpose by an established and functioning organization, made it particularly valuable in assessing organizational adaptation to a changing environment.

In addition, the fact that it became a continuing care retirement community at a relatively early date, early in terms of other such facilities, meant that the whole process of development, and in one sense the evolution, of this type of living arrangement could be explored with the very people who were responsible for the shift in purpose. That in itself makes Pine View Village a valuable tool for understanding continuing care as a viable living arrangement for elderly people.

Data were gathered from vice presidents, department heads, and several lower level employees. Data collection consisted of face-to-face interviews that lasted approximately one hour. For those who were in particularly relevant positions of authority or who were in a position to have access to relevant data, the interviews were considerably longer.

In addition to the face-to-face interviews, access was granted to historical documents, legal documents, agreements between Pine View Village and the residents, documents relating to licensure and certification,

descriptive materials concerning the organizational structure of the facility, financial documents, and a wide array of documents relating to the demographic profile of the resident population. Promotional brochures and in-house newsletters were also made available.

Because of the wealth of information that was made available, it has been classified, for convenience, into three categories. The first of these consists of organizational documents and includes all documents related to the actual organization itself, including reports about the staff and demographic reports on the resident population. Legal documents refers to all documents relating to regulation, certification licensure and any legal agreements between the residents and the facility. Finally, historical and promotional documents includes all documents that describe the development of the community or its current status. Table 5 depicts the categories and the types of information contained in each of these categories.

Pine View Village is unique for several reasons. Not only was it established for a purpose that is only remotely reflected in its current operation, implying organizational adaptation, but it does not conveniently fit into Florida's state regulatory categories. To be sure, in every practical sense, Pine View Village is in fact a continuing care retirement community. However, because no entrance fee is charged it does not meet the statutory definition in force at the present time.

Table 5

Classification of Information From Continuing Care
Retirement Communities in the State of Florida.

Category:	Type of Information
Organizational Documents	Organizational Charts.
	Staff Utilization Reports.
	Budget Projections.
	Current Financial Reports.
	Resident Population Statistics.
	Resident Placement Projections.
	Supply Reports.
	Documents Related to the Day-To-Day Operation of the Facility.
Legal Documents	Papers of Incorporation.
	Aggrements Between Residents and the Facility.
	Licenses, Certificates, and Inspection Notices (as well as all supporting reports and documentation).
	Reports Made to Regulatory Agencies.
Historical and Promotional Documents	Newsletters.
	Brochures.
	Newspaper Articles.
	In-House Historical Accounts.
	Outdated Documents Related to the Day-To-Day Operation of the Facility.

That this is true is of little practical significance here primarily because the operational definition suggested in Chapter One is based upon the special services offered and the reasonable expectation of life-long care, both of which are provided by Pine View Village. In addition, both the officials of Pine View Village and the resident population consider the facility to be a continuing care community regardless of its classification by the State of Florida. In fact, in several instances the promotional literature actually describes the facility as a continuing care community.

State regulatory personnel are well aware of this situation and have suggested, informally at least, that Pine View Village be licensed as a continuing care retirement community or that the statutes be changed so that communities offering continuing care, regardless of whether they charge an entrance fee, are classified, for regulatory purposes, as continuing care retirement communities.

Whatever the outcome, that Pine View Village is in fact a continuing care retirement community cannot be seriously challenged based upon the definition used here. The state bases its definition on the singular question of whether a community requires an entrance fee. The definition used here is based upon the services that are offered to the residents.

But, the definition itself suggests a potential problem. The problem is this: If Pine View Village is in

fact a continuing care retirement community that is operating without a continuing care license, are there other such communities within the state that "fall through the cracks" in the licensing legislation and if there are, are they fundamentally different from the licensed facilities?

In any living arrangement elderly people can and oftentimes do purchase the types of services available in continuing care retirement communities. In most of these cases, the state regulatory mechanism is, if it is involved at all, involved in only the most tangential way. However, when such services are offered as a fundamental component of a lifestyle then several of the state agencies are involved in licensing, inspection, certification, and other regulatory activities.

Undoubtedly there are facilities that offer health related services and that do not meet the state definition of a continuing care retirement community. However, inquiries to the primary state regulatory agencies have produced no evidence that such communities are a widespread phenomenon. And we are confident, based upon a reasonable effort to locate such communities, that even if they do in fact exist, they represent a very small number when compared to the licensed facilities. In addition, similar to Pine View Vllage, it is also likely that these facilities are among the older communities.

Harbor Cove

In order to broaden the base upon which the questionnaire was constructed and, in a sense, to corroborate the information obtained at Pine View Village, another continuing care retirement community was chosen for a case-study, although admittedly a less in-depth case-study. Unlike Pine View Village, this facility, which will be referred to by the pseudonym "Harbor Cove," is located in an urban area along the West coast of Florida. This facility was established as a continuing care retirement community and is licensed as such by the State of Florida.

Like Pine View Village, Harbor Cove was selected as a site for several reasons related to its history and its population. First, because it was established in the early 1970s, it is among the first of the facilities that emerged as planned continuing care communities in response to the growing demand for a living environment that offered supportive care. The fact that Harbor Cove has been in continuous operation through a period of substantial modifications to regulatory statutes, puts those who have had to deal with such changes in a particularly advantageous position to judge their overall impact on the organization.

Phase II: The Comparative Study

Although many departments of the state government are involved in the operation of continuing care retirement

communities, primary responsibility for regulation and inspection falls on only two. The Department of Health and Rehabilitative Services is involved in the operation of the nursing home and Adult Congregate Living Facility portions of the communities and the State Department of Insurance is involved in regulating the continuing care agreements between the residents and the facilities.

Regulation of continuing care retirement communities under Chapter 651 of the Florida Statutes has produced a list of sixty-three currently fully licensed facilities and thirty-four provisionally licensed facilities. Among these are a wide variety of communities including: profit and non-profit facilities; those that offer nursing services and those that do not; those that have strong ties to a particular religious or fraternal organization and those that have no such affiliations; facilities designed to house as many as eight hundred ninety-four residents and facilities designed to house as few as sixty-four.

The administrator or "contact person" of all ninety-eight facilities on the two lists, with the exception of Pine View Village and Harbor Cove, were contacted by mail and were asked to complete a questionnaire. Where an administrator was responsible for the operation of more than one facility, he or she was asked to complete a separate questionnaire for each community.

The actual questionnaire consisted of forty-seven questions developed in the case study phase of this research and included both forced choice and open-end questions. There were two main foci of the questionnaire. First, information was requested about the current status of the facility. Because the number of possible combinations of the variables relating to size, affiliation, costs, and the number of levels of care is vast, information about the day-to-day operation of the facilities was used to construct broad categories of facilities with similar attributes.

The second focus of the questionnaire was specifically related to the organizational aspects of the facilities. Information was requested on both structural issues and the interorganizational relationships between the individual facilities and the organizations in their operating environments. Again, broad categories of continuing care retirement communities were constructed based upon the organizational complexity of the particular community.

Questionnaires were sent to all facilities licensed as of April 1986. Follow-up letters were sent at two weeks and four weeks after the original mailing. In addition, approximately two weeks after the second follow-up letters were mailed, additional copies of the questionnaire were mailed to facilities that had not yet responded.

Among the facilities listed on the provisional list only three were in actual operation and one of those three

had been in operation for less than one month. Data from this last facility were incomplete due to the fact that only a small percentage of the residents had actually moved in and not all of the services and programs were operating. Data from this facility were excluded from the analysis.

In addition, four of the fully licensed facilities declined to take part in the research. Two of the respondents refused because of the time involved in completing the questionnaire. One additional facility was no longer in operation and the final refusal was due to the fact that the community had just filed for bankruptcy and the official in charge thought it inappropriate to complete the questionnaire at the present time.

In all, questionnaire data were gathered from forty-one continuing care retirement communities including Pine View Village and Harbor Cove. This represents a return rate of 65% (41) of the operating facilities in the State of Florida. Thirty-five percent (22) either declined to participate (7) or did not return the questionnaire (15). Three additional attempts to contact this latter group by mail and by telephone were unsuccessful in increasing the response rate. Subsequent telephone contact with eight of these communities indicated those who failed to respond probably did so purposely and therefore, they could be counted among those who refused.

Among the facilities that did respond, twelve of them failed to include information on the organizational

characteristics and the fee structure of their particular facilities. Since this information is vital to the analysis, all twelve of these facilities were contacted by telephone. The result was that complete data were finally obtained from eight of the twelve communities. Four of the twelve communities declined to provide information about their organizational structure and three of those also declined to provide their fee schedules.

Additional Data

The combination of face-to-face interviews, survey questionnaires, and content analysis of internal and external documents has produced a clear picture of continuing care retirement communities as complex organizations. However, because this study emphasizes not only the structural components of these facilities but their operating environments as well, more information was needed from the environment itself.

Following a preliminary analysis of the case study data it was determined that one of the major sources of environmental uncertainty for these facilities was related to the regulation of their day-to-day operation. Thus, both the Department of Health and Rehabilitative Services and the Department of Insurance, as the primary regulators, represented the main sources of environmental uncertainty for these retirement communities.

In order to add information from the environment to that already collected from the organizations, face-to-

face interviews were conducted with representatives from each of the two regulatory agencies. These interviews were largely unstructured, however, they were guided by attention to the issues identified as important in the preliminary analysis of the case study data.

Summary

Organizational research has relied on two main methods. The case-study method has been used to gather in-depth information from a small number of organizations. The comparative method, on the other hand, has been employed to gather what can be called "shallow" information from a large number of organizational types or organizations within a particular type. The case-study method has been called "qualitative" research and the comparative method has been referred to as "quantitative" research.

Irrespective of the descriptive labels, it is clear that neither method is sufficient by itself. This is particularly the case in the study of continuing care retirement communities. Because very little information is available about these communities, at least in an organizational sense, the case-study method can provide the type of in-depth information that is needed.

On the other hand, because of the variation in the organizational components of these communities, in large part due to their flexibility in meeting the needs of the

residents, the comparative method provides a means by which the conceptually typical community can be explored.

This study employs both methods in an attempt to gather basic information about both the organizational characteristics of continuing care retirement communities, and the complexity of their operating environments.

The State of Florida provides for two categories of these communities. Those that are in operation as licensed facilities and those that have met most of the licensing requirements but are not in compliance with one or more of the remaining criteria. Usually, the communities that are "provisionally" licensed are awaiting fulfillment of the requirement that at least fifty percent of the available units be reserved by potential residents before they can begin operation.

The inclusion of both categories produced ninety-eight possible contacts of which sixty-three were licensed and operating as continuing care retirement communities. In addition, there were three communities that were included in the study even though they required no entrance fees and thus could have avoided licensure. One community was indeed not licensed and the other two were licensed.

It is suggested that the state's regulatory classification is inadequate and that the requirement of an entrance fee is not a sufficient definitional device. Rather, it is suggested that the types of support services

available to the residents be used as the delineating factor of what is, and what is not, a continuing care retirement community.

Twenty-two in-depth, face-to-face interviews were conducted at two sites chosen for their availability and the fact that they were located in quite different surroundings. Questionnaire data were obtained from a total of forty-one communities. That represents an overall response rate of about sixty-five percent.

In addition, questionnaire data were made available for six other communities located in Alabama and California. These data are not used in any of the summary tables or calculations, but rather provide corroborative evidence for the data collected from communities within the State of Florida.

Finally, face-to-face interviews were conducted with representatives of both the Florida Department of Health and Rehabilitative Services and the Florida Department of Insurance. These two organizations are the primary regulatory agencies for continuing care retirement communities.

CHAPTER FIVE
THE EMERGENCE OF FLORIDA'S
CONTINUING CARE RETIREMENT COMMUNITIES

The continuing care industry did not become firmly established in Florida until sometime around the decade of the sixties. In fact, with the exception of a very few facilities established by fraternal and religious organizations, the idea of providing several levels of care at a single site in order to prolong the independence of the individual resident was largely absent. To be sure, the idea of life-care was not unknown, but it was neither widely practiced nor economically feasible until social changes produced a population of elderly people who were both willing and able to participate in this, and other, non-traditional lifestyles.

The timing of the relatively sudden increase in the number and size of continuing care communities coincides roughly with efforts at pension reform and advances in health care that are generally associated with the early and mid 1960s (Atchley, 1980). Increasing wealth and improved health combined to produce a substantially large population that had both the financial resources and the functional ability to move out of their life-long homes and seek "retirement areas." This in turn, as has been

discussed in Chapter One, lead to the development of both retirement communities and continuing care communities.

The pattern discussed above is supported by the data collected for this study. Fully seventy-eight percent (32) of the respondents reported that their facilities had been established after 1965 and about sixty percent of the total (25) had been established after 1970. Among the ten communities that were established before 1965, nine of them had religious affiliations and the other one was affiliated with a fraternal organization. In contrast, of the facilities established after 1965 only 12 (38%) reported religious affiliation and none of the respondents reported fraternal affiliations.

The communities that were established relatively recently have developmental histories that are quite different from those established at an earlier time. In fact, in order to understand their development, it is necessary to make a distinction between those communities that were established before 1960 and those that were established more recently.

The primary difference between the two groups of communities is that the recently developed communities are more focused in that they were designed to provide a planned "package" of services to a population that is defined on the basis of both functional and financial ability. The early communities, on the other hand, were largely informal attempts at providing a secure place to

live for those of a particular religious or fraternal affiliation and were based, not upon functional and financial ability, but rather, on simple need and personal preference.

In this sense, and in this sense only, the recently established communities may be thought of as the product and latest manifestation of a continuing organizational evolutionary process that has favored communities that are increasingly specialized in terms of the services they offer.

This intuitively attractive idea of organizational evolution should not be overemphasized, however, because not only do the recent facilities reflect the lessons learned in the past, but the older communities have been significantly altered by the presence of the recently established communities.

In this sense, environmental demands have had a major impact on the older communities in that the structural characteristics that have proven successful among the more recent communities have been adopted by the older ones. The idea that the environment can shape the structural characteristics of organizations was first suggested by Stinchcombe (1965). Later, Miles (1980, p. 251) introduced the term "imprinting" to describe the structural impact of the environment. Continuing care retirement communities are especially interesting because they represent what for lack of a better phrase could be called "retro-active

imprinting." That is, the older communities changed their structural arrangements to reflect what is successful among the more recent communities.

The bifurcation between "old" and "new" that is being suggested here can be illustrated by the developmental histories of two continuing care retirement communities. First, Pine View Village, representative of early attempts at meeting the needs of older people, is characterized by frequent organizational adjustment to environmental demands. Harbor Cove, on the other hand, is representative of a more specialized response to the needs of elderly people.

Organizational Adaptation: Pine View Village

The organizational adaptation to a changing operating environment that the early communities have, more or less successfully, been forced into is best illustrated by the well documented developmental history of Pine View Village. This community was established for purposes that are quite far removed from the current goals of the organization. And, the shift in purpose was an intentional and planned move specifically aimed at organizational survival.

Pine View Village has a long and complex history spanning almost eight decades. It was first established as the church affiliated mission of a small group of people who saw an urgent need for a place to care for orphaned children. While the goals and the purpose of the facility

have changed and the affiliation with the church has become less important as well as less obvious in recent years, those who are responsible for the day-to-day operation of Pine View Village today are as committed as ever to what they describe as their "Christian Mission."

In 1904 an industrialist moved his lumber operation to what was a small settlement on a river in Northwestern Florida. Before his death, he donated 140 acres of land along the river bank to a small but firmly established christian denomination from a nearby small town that planned to open a religious "campground." When the lumber operation was closed, the area was left with little industry and few people. The church found itself in possession of a large tract of river front property that was, for all practical purposes at least, wilderness.

The pastor of the church soon discovered that there was little support for the campground idea, so in 1912, in response to several requests by members of the denomination in another state, the pastor of this small church suggested that some sort of orphanage would provide a much needed service and would fulfill the "Christian Mission" of the church.

In 1913 the first five orphans moved into a modest facility and by 1914 the denomination decided that the facility should also be available to its retired ministers and missionaries. Thus, although the impetus to develop the community was the desire to provide homes for children

orphaned by disease and the consequent high death rates of the early 1900s, its retirement community character was established at almost the same time.

By the year 1919 Pine View Village had a population of fifty orphaned children and twelve retirees and was operating what was, in all likelihood, the first multi-level care intergenerational retirement living arrangement in the country.

What set Pine View Village apart from other supportive living arrangements of the time was that in one essentially non-institutional location the levels of support were individualized for each resident. That the support services were largely informal and neighborly, or that few true medical services were available is, for our purposes at least, unimportant.

Whatever the practical or religious reasons for mixing retired ministers and their families with orphaned children, the impact was that Pine View Village established, at a very early period, a community based on the idea that whatever was needed in the way of support services could be provided at a single location. And, this idea is the basis for the modern continuing care retirement community.

It is not important, at least from a practical perspective, that the geographic isolation of the area and religious predilections of the people dictated a certain amount of neighborly, if unorganized, support. What is

important is that the whole community was, from its very inception, an alternative to both the institutional living arrangements available to retired elderly and orphans at the time, and to the traditional living arrangements as well.

In its early history, Pine View Village remained a more or less denominational community seeking and admitting only those who were members of the sponsoring denomination. However, because of the depression and the general economic troubles of the times, the facility was constantly in financial difficulty and it was apparent that the denomination could not, by itself, support the facility.

Sometime in the 1930s a decision was made to allow anyone of any religious background to become a resident of Pine View Village. This new admissions policy meant that by 1934, four-hundred children and one-hundred elderly people of various religious faiths had lived in the community since it began operation. Still, the financial difficulties persisted. In addition, several fires had destroyed some of the buildings and the first of three major floods had done extensive damage and caused the evacuation of all residents.

Although it is not likely that the fact was recognized at the time, Pine View Village represented one of the first true life-care communities in the country. Those who were ministers and missionaries of the founding

denomination were essentially guaranteed lifetime housing and care at the facility. This only added to the financial difficulties, so in the 1950s the idea of a guaranteed lifetime of care was discontinued in favor of what could best be described as a "fee for services" payment arrangement, within the context of what the organizer's called "continuing care."

This shift in the way services were financed contributed directly to the development of the array of services that now characterize the continuing care component of Pine View Village. By charging the residents for the services that they needed, the facility could better judge the quantitative aspects of a particular service and thereby more efficiently use the limited resources that were available. More importantly however, was the fact that, since services were being paid for by those who needed them, new and innovative levels of care could be explored. Put simply, within the limits of the financial resources of the residents and the competence of the staff to provide a particular service, whatever was needed could be obtained.

From an organizational standpoint the impact of this change was practically significant. Although the facility still had to make a judgement concerning the types and levels of services that would be needed in the future, the fact that it was no longer solely dependent on financial resources paid in the present to finance future services

meant that decisions concerning the future provision of care were less critical. Obviously, if the amount of services that are required are paid for at the time they are delivered, the organizational decision-making process is simplified and the element of prediction is far less important.

This is not intended to suggest that all uncertainty and risk were removed from the decision-making process or that the officials of the organization were no longer required to make long-range predictions based upon current trends and what amount to little more than guesses made from incomplete information. The organizational significance of this change lies in the fact that predictive processes were made less critical but they were not eliminated.

Where the change has had the most impact is in the delivery of health care services. Recent trends have shown an increasing spiral of costs that has defied accurate prediction and the bankruptcy of several of these facilities has demonstrated that the ability of life care retirement communities to predict future costs has been less than adequate. By making the accurate prediction of future needs less critical, organizational survival was enhanced.

Technically, before this change, Pine View Village was in fact a life-care community as it is defined in Chapter Three. The contract between the denomination and

the individual minister or missionary, as well as the agreement of the newly admitted lay people, whether actually written or oral, was understood to include a guarantee of lifetime care. After the change in funding, the facility became what is being referred to here as a continuing care facility. The reason for this is that although there remained a reasonable expectation of lifetime care the actual availability of care depended not upon any guarantee by the operators, but rather, on the ability of the residents to pay for such care and the availability of space at the various levels of care.

Since the early 1950s continuing social changes and medical advancements meant that fewer and fewer children were in need of orphanages. This had two primary implications. First, if Pine View Village was to continue to serve the needs of children, something that it was established to do, then it would have to redirect its efforts away from providing simple housing and family support for otherwise normally functioning children. Second, it meant that the efforts of the facility could be partially redirected toward serving the needs of the expanding elderly population. The first of these tasks was accomplished by redefining the target population of children to include those who were emotionally disturbed and those who needed more support and care than was previously available. The second task was addressed by expanding the levels of care available to elderly people to include nursing home care.

In 1958 Pine View Village opened a twenty-two bed nursing home that marked the end point of the continuum of care provided at the facility. It also marked the beginning of a new emphasis on the needs of the elderly. By 1969 only thirty-six children lived in Pine View Village, but one hundred and seventy-five elderly persons were residents. By 1971 the facility was certified by both medicare and medicaid and had expanded the nursing home to serve forty-four residents. Recent developments have added two multi-story apartment buildings, that offer a range of support services and several financing plans, as well as a mobile home park, clustered apartments, and single detached dwellings that are a part of the community.

The ability to shift the emphasis from caring for orphans to providing a variety of services for children and adults was directly responsible for the organizational survival of Pine View Village. In fact at each of the self-identified crisis points in the long history of this facility, the organizers have shown a willingness to attempt a variety of new programs in an effort to meet the needs of its residents and continue the operation of the community.

The result has been the evolutionary development of a facility with several levels of care directed at both children and elderly adults. And although the services to children remain an important and vital component of the community as a whole, there is a noticeable emphasis on

the programs directed toward the elderly. From the early beginnings as an abortive attempt to establish a religious campground on one hundred forty acres of wilderness along a river bank, Pine View Village has grown into a nine hundred acre community that serves elderly people, families, and children, that employs over two hundred and seventy people, and that has an annual budget of over seven million dollars.

From the very beginning those who organized Pine View Village saw it as an extension of their "Christian duty" to their fellow human beings. The community was based on a philosophy of providing services to those members of the denomination who could not provide for themselves. When the philosophy was expanded to include persons of all faiths, the underlying "Christian duty" idea remained.

The notion of a religious or fraternal "duty" is common among the early communities and is, in one sense, analogous to what Aldrich (1980) and others, would call "organizational goals." However, based upon the documents and historical accounts made available by the communities in this study, the "duty" referred to here has an element of compulsion that is absent in the idea of an organizational "goal."

Put another way, goals are standards of performance to which an organization aspires while duties are standards that one is compelled to meet. In this sense, organizations with a religious or fraternal duty to meet

the needs of their constituents are probably more likely to adjust the elements of the organization in response to environmental demands if only because fulfilling the duty requires organizational survival.

In the case of Pine View Village, although the overall influence of the founding denomination has been declining, a process that began almost immediately, the strong attachment to it by those who now occupy positions of authority in the organization remains. In fact most of the officials and many of the employees of Pine View Village are, by personal choice, members of the denomination that founded the facility.

In response to the shift in emphasis from children to retired adults, the organizers of Pine View Village attempted to define the policies regarding admissions in such a way as to include the broadest possible base from which to attract new residents. They have also attempted to establish policies for admissions that encourage diversity of age, gender, and geographic origin.

As a matter of both official policy and practical application, persons from all religious backgrounds are accepted in the community. Still there is an effort made to place members of the founding denomination whenever possible. In addition, the community professes not to discriminate on the basis of race, national origin, sex, or age.

However, the organizers have established informal preferences with regard to age, gender, geographic

origins, and health status. In each case the effort has been made to attract a wide diversity of residents in the belief that a wider range of life-experiences leads to a more stimulating living environment. For example; currently, about seventy-five percent of the residents of Pine View Village are female. The organizers have stated that gender is not a criteria for admission while at the same time they have stated their belief that a more equal mix would be desirable. Similarly, about thirty-five percent of the residents are from states other than Florida. This is viewed as a desirable situation because the organizers believe that it encourages social contact among the residents.

Organizational Stability: Harbor Cove

The organizational history of Pine View Village can be characterized by fundamental adaptation and change. The relatively short and considerably less complicated history of Harbor Cove, on the other hand, is one of stable adherence to goals established at the time the community was first established.

Unlike the early communities, that added services as needs became apparent, Harbor Cove was a planned community in the sense that all of the services it now offers were established at the time the facility first opened. In fact, although state licensing designations have been revised since it opened, Harbor Cove was, from its very inception, dedicated to providing a continuum of care that

included both assistance within the resident's apartment, now called home help or home assistance, as well as assistance in a common area, or what is now called Adult Congregate Care.

As alluded to above, the fundamental difference between Harbor Cove, and the recent communities that it represents, and the early communities, represented by Pine View Village, is that while the recent communities planned a "market" package of services based upon the anticipated preferences and financial abilities of a general target population of elderly people, the early communities had evolved a package of services in response to the demonstrated needs of a well defined target population.

This difference is even apparent in the way the two types of communities were established. In the case of Pine View Village, the original plan for the land was quite different from its current use. It is also reasonable to conclude that, since standards of operation were not yet established when most of the early communities were founded, the organizers and sponsors had only a vague idea of the structural and organizational characteristics that these communities would develop.

The case of Harbor Cove and the recently developed communities is generally and fundamentally different. In these communities all facets, whether structural, organizational, or programmatic, have been formalized and approved by the various regulatory agencies well in advance of the actual arrival of the resident population.

In fact, the statutory requirement that at least fifty percent of the available spaces be reserved by potential residents before a continuing care retirement community can begin operation means that the package of services and the character of the community are set long before any services are actually delivered.

The importance of this difference should be emphasized. For one thing it suggests that, because of the somewhat volatile past experienced by the early communities, they may be more flexible in responding to environmental demands than are the recently established communities.

Also, since organizational stability is undoubtedly related to the stability of the operating environment, the very fact that the early communities have faced and survived a turbulent environment means that they have already established adaptive mechanisms that may be lacking in the more recent communities. This could have a profound impact on the continued survival of these communities especially if the future is a volatile one. The important point here is that organizational stability is not necessarily an entirely positive occurrence, especially if a community faces a future that is substantially more risky than its past.

Summary

The timing of the increase in continuing care retirement communities in Florida coincides roughly with

advances in health care and pension reform that produced a sudden increase in the population of elderly people who were healthy and reasonably secure in a financial sense.

The diversity of needs and preferences in housing arrangements for this population began to be expressed in the expansion of the available alternatives, both through the establishment of new types of housing and through innovative additions to facilities already in existence.

Florida has two distinct types of continuing care retirement communities. First, there is a small group of communities that predate the changing social, financial, and health conditions of the elderly. These tend to be affiliated with religious or fraternal organizations, and although most of them now accept any potential resident, some still give preference to members of the sponsoring denomination or organization.

The second group of communities was established after about 1965. Although some of these have religious affiliations, generally speaking, any elderly person is accepted as a resident.

There are, however, more important differences than mere affiliation. For one thing, communities that were established early have what could be called "evolutionary histories" in that they were already functioning when the regulatory mechanisms were established. Although in some cases the changes required were minimal, some of these communities were required to realign their organizational structure.

The communities that were established later tend to have what can be called "anticipatory or planned histories." These communities were established under state regulations that required certain organizational arrangements and specific performance standards.

Thus, while the early communities were operating largely in reaction to environmental uncertainty and "in the dark," so to speak, the communities established later had the benefit of regulations that themselves suggested possible problem areas requiring attention.

CHAPTER SIX
HOUSING TYPES, LIVING ARRANGEMENTS, AND
SUPPORTIVE SERVICES IN FLORIDA'S CONTINUING
CARE RETIREMENT COMMUNITIES

It is reasonable to conclude that the notion of a continuing care living environment, consisting of a graduated scale of support from independent living to institutional living, grew out of the need for more and less supportive alternatives to what now represent the end points on the conceptual scheme referred to here as the continuum of care. Equally reasonable is the notion that these intermediate levels of care are the formal manifestations of care levels that have always been provided on an informal basis by family and friends.

The services offered by modern continuing care retirement communities are a direct result of the general unavailability of a wide variety of supportive services for those who did not need nursing care but who were unable or unwilling to live independently and who could not obtain the services from family or friends. Consequently, any attempt at a precise typology of supportive services is hampered by the very flexibility that characterizes these communities. Adding to this difficulty is the fact that the legal definitions involved are also imprecise and somewhat flexible.

As mentioned in a previous chapter, the legal definition of continuing care may be quite different from what individual communities define as continuing care. Legal definitions are intentionally broad so as to include as many different living arrangements as possible, many of them only on the periphery of what, from a purely practical viewpoint, can reasonably be called continuing care.

This point is illustrated by the fact that all that is required for a facility within the State of Florida to meet the legal definition of a "Continuing Care Retirement Community" is that it provide some sort of "personal service" and that it charge an "entrance fee." The overall result is that continuing care retirement communities in the State of Florida offer a wide array of different combinations of services to their residents. And, these services are delivered in a widely diverse array of physical settings.

The existence of supportive services is the primary distinguishing characteristic of the definition for continuing care retirement communities suggested in Chapter One. Whether conceptually envisioned as a continuum of care or a collection of discrete services applied on an at need basis, it is the nature of the supportive services themselves that separate these communities from both stand-alone institutional living and what can best be described as traditional independent living.

However, any discussion is confused by the context within which the services are delivered. At the same time, one must consider three separate but closely related issues when attempting to characterize these communities. "Housing types" refer to the actual physical structures within which the services of the community are delivered. "Living arrangements" reflect the individual resident's linkages to his or her fellow residents, to the organization that operates the community, and to the larger context of the living environment. Finally, "service type" refers to the extent and the intensity of support services that a particular community provides.

These three issues are separate in that none of them is an adequate summary statement of the characteristics of continuing care. They are related in that each does, at least to some extent, describe an important element of this type of community and each is more or less descriptive of the context within which the others exist. The result is that all three issues are important in understanding continuing care communities, but constant effort is required to avoid confusing the underlying concepts.

It would be convenient indeed if the type of services provided by a particular community corresponded in a precise way with a particular type of physical structure. Unfortunately, although there is undoubtedly a connection between the types of services that a community can provide and the nature of its physical structures, the

relationship is by no means obvious and in some cases is quite confusing.

For example, some licensed Adult Congregate Care Facilities within continuing care communities are physically separated from other housing types, while others are no more than labels assigned to a series of otherwise unconnected apartments within a larger independent living arrangement. In contrast, most of the structures where nursing services are provided are not only easily identifiable but they are usually physically segregated as well.

Adding to this confusion, as one considers the two polar ends of the continuum of care, the labels used to describe the types of services offered are more descriptive of the actual settings. Thus, although the designations "independent living" and "nursing home living" are descriptive of both service levels and housing types, the term "assisted living" is less so.

Similarly, the term "individual apartment living," a term often used by organizers, developers, and residents, to describe a particular housing type, can be confusing when it is understood as a description for a living arrangement. In fact, the term has been used to describe both apartments with little or no support services as well as those with housekeeping and meal services. The difficulty of confusing descriptive labels is not unique to multi-level care retirement communities. Quite the

contrary, it is one of the major issues in the study of any non-traditional living arrangement (see Streib, Folts and Hilker, 1984).

The obvious, but unsatisfactory, way this problem has been addressed involves considering the issues of housing type and service levels separately. What makes this approach unsatisfactory is that it obscures those interconnections between service types and physical structure that do exist, and forces research to either consider service levels as the only meaningful criteria for categorizing living arrangements or focus on each as separate and unrelated phenomena. For our purposes, we will consider the three issues separately and then attempt to demonstrate the interconnections between them.

Housing Types

Among the three issues identified above, the simplest to define is housing type. Continuing care retirement communities are typically made up of a combination of housing types. These types may be categorized as including single detached homes, individual single occupant apartments, shared apartments, clustered apartments, or, in the special case of nursing homes and some ACLFs, shared rooms. In fact, almost any housing type found in traditional communities can also found in continuing care communities, however, some housing types are clearly more common than others.

By far the most common housing type found in these communities is a series of apartments in a single apartment building, occupied by a single elderly person or, less frequently, a married couple. The apartments are usually grouped into one or more multi-story buildings with a common dining area.

Less common but also important is the type of building characterized by clustered apartments. Here, apartments, typically in groups of four to six are clustered, or attached, such that they share a common wall and common open spaces but all have private entrances. Only rarely are conventional single detached homes included in these communities, but they do exist.

Living Arrangements

A somewhat more difficult issue with which to deal is the issue of living arrangements. Here we have defined living arrangement as the linkages among the residents, between the residents and the organization, and between the residents and the larger context of the living environment. In this sense, living arrangements may be viewed as the type and character of the support relationship that exists between the community and the individual residents.

Inasmuch as continuing care retirement communities are established for the specific purpose of providing varying levels of care to those who need it, an individual

resident's living arrangement may be viewed as an indicator of his or her level of dependency.

As suggested by Streib, Folts and Hilker (1984), living arrangements can be simplified into only three categories: independent living (i.e., unassisted living), assisted living, and supervised living (i.e., nursing home and congregate living arrangements).

Those who seek out the types of living arrangements available in continuing care communities either need or anticipate needing a more supportive living environment than they themselves are able to provide. Thus, the term "living arrangement" as it applies to continuing care communities may be conceptualized as the extent to which a resident depends upon the services of the community. Generally, as the residents become more frail, their dependency on the support services of the community increases. Thus, a particular resident's living arrangement is somewhat fluid and is redefined based upon what he or she needs from the community at any given point in time. Generally, as service intensity or extent increase, the assumption can be made that the individual's level of dependency has also increased.

The relationship between living arrangement and service intensity is an obvious one. As an individual resident passes from independent living (or unassisted living) to assisted living and finally to supervised living, he or she requires increasingly more support from

the community. Former linkages are redefined to reflect this new level of functional ability.

Less obvious, but just as important, is the relationship between living arrangement and housing type. As residents become more frail they require increased services from the community. There is a point at which economies of scale dictate that the services, and the people who require them, be concentrated in an area that is, if not physically separated then clearly defined as, segregated from the remainder of the community.

Independent Living

Perhaps the easiest living arrangement type to describe is the category of independent living. By definition, the people who occupy these living arrangements are independent and in need of minimal services. However, the very nature of the community means that at least some support is provided, even if that support is only the residual effect of living in a more or less secure housing type with persons of similar financial means and chronological experience.

There is, however, some variation in even this the simplest of the categories. In some continuing care retirement communities, independent living means that the residents involved are completely "on their own," so to speak. This lifestyle, except for the fact that it is a retirement village, is for the most part indistinguishable

from living in what most people would describe as living in a "normal" community.

In other settings, activities, programs, and medical help is made available to even those who live independently. In these communities, the differences between independent living and the least supportive of the "care" arrangements are not as clear. In all cases, however, independent living is defined as the ability to live in the community without supportive services and in all but a very few instances, formal services are neither needed nor delivered to those in independent living arrangements. In this context, even in communities where the differences between living independently and living in the lower levels of care are not clear, those who live independently and in fact do receive some of the formal services are assumed to use the services as a convenience rather than as a necessity.

The exception to this is in the area of services related to transportation. Given the fact that the average ages of the residents in Florida's continuing care retirement communities is approximately 81 years old (81.32), it is not surprising that transportation to and from locations outside the community is an important service that even those living independently are likely to utilize. In fact, fully 75% (31) of the communities in this study list transportation services as one of the most important services offered, and it is reasonable to assume

that those residents who are most active, i.e., those who are living independently, are the ones who use the transportation services most.

Assisted Living

The most complicated of the categories of living arrangement offered by these communities is generally referred to as assisted living. The lack of clarity is due in large part to the wide and diverse array of services that are typically available and to the fact that service levels are generally determined by the individual needs of particular residents. In general, however, assisted living is defined by services that are directly related to accomplishing the tasks of daily life.

Supervised Living

Supervised Living as a category of living arrangement is generally thought of as skilled or intermediate nursing care. However, several of the communities in this study have developed variations that are well short of full care but at the same time offer the resident a supervised environment at a central location.

Regulatory statutes divide nursing care into skilled nursing care, the most supportive, and intermediate nursing care, that is somewhat less supportive. The defining characteristic of both designations is an assumption that the individuals involved need constant supervision, if not constant medical attention, and that they cannot survive on their own.

Since the very purpose behind of the development of continuing care retirement communities was to offer services that would delay institutionalization, it is not surprising that within many of these communities there are living arrangements that are less restrictive than nursing homes but, at the same time, offer twenty-four hour supervision for those who cannot function on their own. Although regulatory designations differ, one of the most common designations, and the one in use by the State of Florida at the present time, is Adult Congregate Living Facility (ACLF).

The State of Florida's regulatory statutes define an ACLK as

Any institution, building or buildings, residence or private home, boarding home, home for the aged, or other place, whether operated for profit or not, which undertakes through its ownership or management to provide, for a period exceeding twenty-four hours, one or more personal services for four or more adults, not related by blood or marriage, who require such services. (Fla. Code, CH. 400.402.4)

The primary distinction between an ACLK and the more traditional nursing home, at least from a statutory and regulatory viewpoint, is that an ACLK provides personal services rather than medical services. In practice, however, ACLKs that are organizationally a component of continuing care retirement communities tend to be treated as a third and considerably less restrictive level of nursing care.

Service Types

In any discussion of support services a distinction must be made between the types of services available; the extent, and the level of the services actually delivered to the individual; the intensity. Although the two concepts are related, they are in fact separate concepts. Among continuing care retirement communities there is wide diversity in the intensity of services delivered to the residents but there is little variation in the extent of services that are provided.

Typically, continuing care communities offer at least three main subcategories of supportive services: personal care, homemaker services, and transportation services. In addition, some communities offer adult day-care and other temporary supervisory services that are particularly valuable when one spouse is functionally disabled and the other is not.

Personal Care

Personal care is a somewhat broad group of services that range from help with ambulation and cooking to help with personal hygiene, dressing, and management of medication. In most cases personal care services are directly aimed at providing needed services in order to avoid, or at least postpone, the institutionalization of the individual resident.

Homemaker Services

A related group of services is typically referred to as homemaker services. These are services directed at day-to-day housekeeping tasks. Light housekeeping, laundry services, assistance in shopping, transportation, and meal preparation are commonly grouped in this category. In addition, some communities deliver meals to their residents, much like the "meals on wheels" programs in age integrated communities.

Transportation Services

The third subcategory of services that are typically provided to residents in these communities can be labeled transportation services. This group of services can range from the rather modest effort of providing transportation to and from the resident's personal physicians on a regular, formal, and quite inflexible schedule, to the more ambitious effort of providing transportation, to any location within a limited area, on demand. The typical pattern is somewhere between these extremes and usually involves medical transportation, including visits to the resident's personal physician as well as visits to pharmacies, and supermarkets on a relatively flexible but formalized schedule.

In addition to these essential transportation services, most continuing care communities offer some level of transportation for recreational and entertainment purposes. These services tend to be offered on a more rigid and inflexible schedule.

The Interrelations of Housing Types Living
Arrangements and Service Types

Because of its diversity, Pine View Village is especially useful in illustrating the interrelationships among housing types, living arrangements, and service types. Table 6 is a summary of information about the different housing and service options that are available to the residents of Pine View Village.

Housing Types

There are two multi-story apartment buildings that have been constructed with federally insured long-term loans from the Department of Housing and Urban Development. In addition, there are twenty four cluster homes, built in clusters of two, three, and four units, single detached homes for independent persons, and a small mobile home park. Finally there is a nursing home facility that provides three levels of care.

The private single-detached homes and cluster-homes are built by individuals on land that is leased from Pine View Village. This idea began as a response to long waiting lists for the other living arrangements. It is a way for a person or a couple to become a part of the community before space in the other housing types is available.

Although there are broad restrictions on the size and type of home that can be built, there is still wide diversity in the houses currently located in the

Table 6. Physical Facilities of Pine View Village.

Type of Facility	Cost	Number of Units	Services Included
Four-Story Apartment Building	\$354-\$400/Month Federal Subsidy Available for Low Income People.	50 Efficiency Apts. 30 One Bedroom Apts. <u>80</u> Total Units.	Emergency Warning System Carpeting, Drapery Rods, Garbage Disposal, Stove, Refrigerator, Water, Sewage, and Utilities Access to Support Services
Six-Story Apartment Building	363/Month or 30% of Income.	95 One-Bedroom Apts. 5 Two Bedroom Apts. <u>100</u> Total Units.	(Same as above except resident pays utilities).
Cluster Homes (Duplex, Triplex, and Quadplex Arrangements).	\$250-\$330/Month	14 (935 sq. ft.) 6 (660 sq. ft.) 4 (560 sq. ft.) <u>24</u> Total Units.	Emergency Warning System, Smoke Detection System, Garbage Pick-up, Water, Sewage Costs, Lawn Care. Access to Support Services
Single Detached Homes	Variable	Variable	Security Services Access to Support Services
Nursing Home	\$1,597-\$2,082/Mo.	91 (Skilled or Intermediate) 16 (Other) <u>107</u> Total Beds	Nursing Services Room. All Meals. Utilities.
Mobile Home Park	\$88-\$98/Month	32 Single Spaces 5 Double Spaces <u>37</u> Total Spaces	Emergency Warning System Smoke Detection System Garbage Pick-up Water and Sewage Costs Lawn Care Access to Support Services

community. Those who build dwellings in this manner, are considered a part of the community and have access to all of the facilities and services offered by the community. Although there is a rental fee for the land upon which the dwelling unit is built, maintenance and insurance costs, except for personal property, are paid out of that fee.

When the builder and his spouse die, the operators of Pine View Village, quite reasonably, expect to have the ultimate decision-making power in approving the new owners. This is done within the context of the residency requirements for the community as a whole and presents few practical problems.

Despite the fact that the community has extraordinary power in deciding when and to whom the houses can be sold, there are advantages to this arrangement for both the community and the residents. As noted above, the recent history of Pine View Village has been characterized by long waiting lists. This type of housing is available, for all practical purposes, whenever the potential resident is ready to move. As might be expected, the costs of building a single-detached home are highly variable and dependent both on the type and quality of construction.

The cluster homes come in two basic prices and are arranged in clusters of four units. The standard one-bedroom model is 783 square feet and costs \$37,500. The standard two-bedroom model is 1,041 square feet and costs \$46,000.

Similar to the cluster homes are the "terrace apartments." The difference between the two is that the clustered homes are actually purchased by the potential residents while the terrace apartments are built by the community. The terrace apartments available in Pine View Village are laid out in duplex, triplex, and quadplex arrangements.

Pine View Village currently has fourteen units with a living area of 935 square feet, six units with 660 square feet, and four units with 560 square feet of living space. The costs of these units vary between \$250 per month and \$330 per month depending upon the size of the unit.

Viewed from the perspective of the community, the only meaningful difference between these clustered apartments and the apartments located in the multi-story buildings is that in the clustered apartments, no rent supplements are available. From the residents standpoint, however, these apartments may be more attractive because they are all one-story buildings with individual entrances and because there is no stigma of low-income rent supplements attached to them.

In the early 1970s officials of Pine View Village came to the realization that it was not likely that organizational goals could be met with financial resources available from private donations, the denomination, and revenue generated by resident's payments. For that reason the community sought and received grants and low interest

loan guarantees from the Department of Housing and Urban Development for the purpose of constructing two multi-story apartment buildings.

The first, opened in 1974, is restricted to those 62 years of age or over and has fifty efficiency apartments and thirty one-bedroom apartments located on four floors. The facility offers rent supplements to the residents based upon their income. For the efficiency apartments, a person with an annual income below \$10,150 would pay \$274 a month in rent. If that person's income is above \$10,150, the rent increases to \$345. In the thirty one-bedroom apartments, for a couple with a combined annual income below \$11,600 the monthly rent is \$317 and for those with higher incomes the rent is \$400.

The second of the apartment buildings is six-stories and was completed in 1981. It too is restricted to persons 62 years old or older, and consists of ninety-five one bedroom apartments and five two-bedroom apartments. As with the other facility, rents are supplemented by the federal government, but here the formula is different.

In this facility, the one-bedroom apartments cost \$363 per month for a single person with an annual income over \$10,150 and for those with incomes below that level the rent is 30% of the person's monthly income. The rates are the same for couples but the combined income level is placed at \$11,600. For the two-bedroom apartments, the cost is \$462 per month or 30% of the residents monthly

income depending upon whether the couple has a combined annual income above or below \$11,600.

In both facilities the costs of an emergency warning system (emergency call buttons) and water and sewage disposal are included in the rent. In addition, in the older facility utility costs are included in the rent as well.

The final two housing options that are offered by Pine View Village are physically located within the nursing home building and are medically oriented medicaid approved facilities. The first is a sixteen-bed facility for persons sixty years old or older who are unable to live without supervision but who do not need medical care. The other is a ninety-one bed skilled nursing care facility for those sixty and older who need constant skilled or intermediate nursing care.

Since both of these facilities are approved for medicaid, the costs to the individual as well as the charges set by the community are regulated by the federal government. The process of setting the rates is a complicated one that is not important for our purposes here, however, the current cost for a semi-private room in the nursing home at Pine View Village is set at \$1,597 per month and for a private room the monthly cost is \$2,082.

Service Types

Pine View Village has developed a program called "Community Care for the Elderly" that provides services to

community members with the expressed purpose of allowing them to live as independently as possible outside the nursing facility. This service program allows individuals who are otherwise perfectly capable of self-care to get help with specific tasks of daily living.

Community Care for the Elderly consists of six basic services: adult day care; "chore" services; personal care; home delivered meals; homemaker services; and medical transportation. Although the program is administered by Pine View Village, it is a pilot program under review and partly funded by the Florida Department of Health and Rehabilitative Services and is available to anyone within a specified geographic area.

Adult day care offers a protective environment, meals, and transportation to and from the delivery site for elderly people who cannot be left alone during the day. This is an especially important service for married couples where one of the spouses cannot be left alone and the other must work or must leave the home for part of the day. In effect, adult day care is a temporary "place to go" when, for whatever reason, an elderly person who is in need supervision cannot be supervised in his or her own home.

Chore services involve assisting elderly persons with simple household tasks and shopping. This component of community care can have a profound impact among elderly people who either cannot or prefer not to drive.

Personal care involves help with bathing, ambulation, housekeeping, cooking, and supervision of medication. Again, the idea is to provide just enough service to accomplish the task, but not enough to make the individual totally dependent.

Home delivered meals is a service similar to what is known as "meals on wheels." A hot meal is delivered to home bound elderly people on a regular schedule. This relieves the elderly person from some of the responsibilities of cooking and shopping, and it insures that at least one meal a day is hot and nutritionally sound.

Homemaker services are directed at the day-to-day housekeeping tasks. Light housekeeping, laundry, assistance in acquiring household goods, assistance in paying bills, transportation, meal preparation, and assistance in shopping are all grouped together under this one category.

Finally, medical transportation provides a reliable source of transportation to and from doctors and pharmacies so that the otherwise home bound elderly person can obtain needed medical services.

In all cases, the cost of the services is determined by the elderly person's ability to pay for them and the difference is paid for by the state. As alluded to above, these services are available not only to all residents of Pine View Village, but to all elderly people in the

designated surrounding area as well. Apart from the exceptions noted below, this program represents the bulk of the support services available to residents of Pine View Village.

The nursing home component of Pine View Village offers three levels of care. The least supportive is for elderly people who do not need constant skilled nursing care but who, for a variety of reasons, cannot live independently. The second and third levels are intermediate care and skilled nursing care respectively and represent true institutional care of the types traditionally associated with nursing homes.

One of the unique features of Pine View Village is its approach to the delivery of supportive services. Because of the Community Care Program any of the support services, with the exception of nursing services, can be delivered to residents in any of the housing types whenever they are needed. This "portable" service approach means that residents need not be physically concentrated in an area in order to receive specific services. Thus, when new services are needed, those services are brought to the individual residents rather than the sometimes emotionally traumatic alternative of moving the resident to a separate facility where the services are available.

Conspicuously absent from the facilities at Pine View Village is an Adult Congregate Living Facility (ACLF). Although the actual services provided by the Community

Care Program are similar, an ACLF lacks the element of portability that allows residents to remain in their present housing type and it requires more or less continuous residence at a specific congregate site in order to take advantage of its services.

Both of the apartment buildings at Pine View Village were, at one time, licensed as Adult Congregate Living Facilities. However, because the officials of the community wanted to emphasize independent living and because they wanted to fully develop the Community Care Program, the decision was made to request decertification of both ACLFs and to rely exclusively on the Community Care Program as the primary non-institutional service delivery vehicle.

Incidentally, the board of directors of Pine View Village has recently approved construction of a new twenty-four bed facility to be completed sometime in 1987. This facility will be a licensed Adult Congregate Living Facility and will operate along side the Community Care Program. When operational, the ACLF function of the new facility will expand the alternatives available, and it is intended to further postpone institutionalization.

Living Arrangements

Although Pine View Village provides a good example of both the housing types and the service types that are generally found in continuing care retirement communities, it is not a typical community in terms of living

arrangements. The portable nature of the services found in Pine View Village tends to blur the relationships between living arrangements and housing types. Since essentially all services, with the exception of nursing services, can be delivered in all of the housing types, the distinctions between independent, assisted, and supervised living arrangements and their relationships to the housing types become less distinct. This is not the case, however, in typical continuing care communities.

Generally, continuing care retirement communities offer independent, assisted, and supervised living arrangements. In addition, assisted living may be subdivided into the further categories of "home help" and "congregate" living arrangements. The typical community is housed in a single multi-story building consisting of relatively small one and two bedroom living units and one or more relatively large congregate living areas.

This produces four living arrangements within three housing types. Table 7 illustrates the common combinations being offered by continuing care communities. The combinations are arranged from the least restrictive, in the upper left corner to the most supportive in the lower right corner.

From a practical perspective, some of the combinations implied by Table 7 are not found. However, either because of statutory regulation or because of economic considerations, there are clear patterns that

emerge and that appear to be more or less consistent throughout the continuing care communities in Florida.

It should also be noted that Table 7, and the combinations it suggests, are intended only as a heuristic device and are admittedly simplifications, perhaps oversimplifications, of very complex phenomena. Still, there is value in conceptualizing living arrangements, housing types, and service types as components of an interrelated "package" containing social, physical, and support elements that when taken together define what a particular community offers its residents.

The matter is made considerably less complicated by the fact that the overarching definitional characteristic of the lifestyle found in continuing care communities is what we have called "living arrangement." Whether a resident lives independently, is assisted, or is supervised suggests not only the services that he or she receives, but also the type of housing he or she occupies. In this sense, then, "living arrangement" can be viewed as the primary classificatory variable in understanding the overall issue of what a particular community offers its residents.

The most basic, and least supportive, of the combinations of living arrangement, service type, and housing type is typified by a resident living independently, with no formally delivered services, in his or her own apartment. Although basic, this combination is

Table 7 The Living Arrangements, Housing Types, and Service Types
in Continuing Care Retirement Communities.

Living Arrangements:			
	Independent	Assisted Home-Help ACLF	Supervised
Housing Types	APARTMENT	APARTMENT	CONGREGATE NURSING HOME
Types of Services	General. Related to Convenience Rather Than Necessity.	Specific. Related to Assistance with Activities of Daily Living.	Specific. More Intense Assistance with Daily Living Tasks. Specific. Related to Medical or Psychological Necessity.
Purpose of Services	Convenience Security	Prevent Move to ACLF or Nursing Home	Prevent Institution- alization Prolong Life. Maintain Quality of Life.

by no means universal. Survey data show that about 86% (35) of the continuing care communities responding to the survey offer this combination. Table 8 presents a summary of the data concerning the living arrangements for those communities responding to the survey.

Those communities that do not have independent living arrangements usually offer a package of services that attract older and more frail elderly individuals. These communities are less oriented toward leisure and recreation, and probably also attract residents who are more concerned with the support services available than with the social environment that is created.

Independent living can also involve some services. As discussed above, however, these services tend to be available throughout the community and are not usually resident specific. The services delivered to residents who are living independently tend to be limited to medically related transportation services and services related to recreation or leisure.

In terms of the housing types of those living independently, most live in single occupancy apartments either alone or with a spouse. It is rare indeed to find independent living arrangements in congregate or shared housing types, but it does occur. When there are individuals who choose to live independently but in a congregate or shared housing type, it is usually because of the security, either mental or physical, that is

Table 8 Summary of Living Arrangements in Florida's Continuing Care Retirement Communities

	Independent		Assisted		Supervised		Total	
	a	b	a	b	a	b	a	b
Community:								
1.	396	396	--	--	102	102	498	498
2.	215	213	40	39	56	45	311	297
3.	100	95	--	--	24	20	124	115
4.	150	123	25	20	42	39	217	182
5.	160	160	40	34	60	60	100	254
6.	--	--	64	60	--	--	64	60
7.	--	--	100	92	--	--	100	92
8.	340	150	40	35	60	56	440	241
9.	492	290	18	18	120	120	630	428
10.	330	300	--	--	107	103	437	403
11.	112	112	10	5	34	16	156	133
12.	100	72	--	--	60	60	160	132
13.	207	200	12	12	21	21	240	233
14.	270	264	90	70	100	97	460	431
15.	277	204	550	30	--	--	827	234
16.	390	317	--	--	60	58	450	375
17.	359	300	44	40	120	120	525	460
18.	650	390	--	--	120	100	770	490
19.	605	538	24	21	110	88	739	647
20.	--	--	372	219	150	138	522	357
21.	442	400	212	193	240	200	894	793
22.	212	118	--	--	--	--	212	118
23.	235	200	30	25	60	60	325	285
24.	--	--	54	50	42	41	96	91
25.	338	265	--	--	43	35	381	300
26.	350	300	52	52	--	--	402	352
27.	188	96	54	32	104	78	346	206
28.	280	190	40	40	60	60	380	290
29.	300	295	50	49	102	99	452	443
30.	200	150	50	50	43	40	293	240
31.	295	295	15	15	60	60	370	370
32.	60	31	54	43	85	69	199	143
33.	--	--	130	91	40	40	170	131
34.	65	60	10	9	--	--	75	69
35.	250	250	75	73	50	50	375	373
36.	550	550	50	50	100	100	700	700
37.	400	221	58	47	20	17	478	285
38.	258	235	100	92	60	57	418	384
39.	228	130	22	18	120	115	370	263
40.	--	--	114	74	85	69	199	143
41.	294	290	18	18	65	63	377	371
Total:	10,098	8,200	2,617	1,716	2,725	2,496	15,440	12,312
Mean	288.5	234.3	79.3	52.0	77.8	71.3	326.6	302.7
s	143.5	123.6	109	46.5	43.8	39.1	208.0	170.6
n	35	35	33	33	35	35	41	41

a = total capacity

b = actual occupancy

afforded by the close proximity of other residents and staff. In this context, it could be argued that security is in fact a service. If indeed that is the case, it is a non-resident specific service, much like transportation.

Assisted living has two components. One is formally licensed as adult congregate living and the other is best described by the term "home-help." The former fits well within the categories suggested by Table 7. However, since home-help is designed specifically to provide services that will prolong what is essentially an independent living arrangement, it does not fit well within the conceptualizations of Table 7. This is particularly true in communities, such as Pine View Village, where a variety of services are mobile and are provided to individual residents in their current living arrangements whenever possible.

However, in typical continuing care communities, there is a tendency to segregate even those receiving home-help such that even though they are living independently, relative to those in ACLFs, they are in fact physically segregated from those who are receiving few, if any, services. For example, a common practice involves designating a particular floor of an apartment building, or section of clustered apartments, as home-help areas.

By thus concentrating those in need of services, the administrators can more efficiently deliver the services.

Over time, this has the effect of clearly segregating the community, by physical location, such that there is a tendency for home-help to become, conceptually at least, no more than a less rigid form of congregate living.

The support services that are delivered to residents in assisted living arrangements, whether home-help or congregate living, tend to be of the types discussed previously. In addition, they are less a matter of convenience, as is the case with residents living independently, and more a matter of compensation for functional disabilities. As suggested earlier, the very purpose of assisted living arrangements is to provide services that enable an individual to remain free of the institutionalization implied by supervised living. To that extent, within the regulatory and financial limitations of the community, the services are individualized.

The final category of living arrangement involves more or less constant supervision of the type generally thought of as appropriate to the nursing home setting. Indeed, although statutory categories clearly define two levels of care, intermediate and skilled, that are based upon an individual's functional ability and medical needs, some continuing care communities have established additional levels for their residents.

For example, Pine View Village offers twenty-four hour supervision to residents who do not need the normal services offered in a nursing home setting but who, for a variety of reasons, cannot live independently or in an

assisted environment. These residents are generally characterized more by mental confusion than by physical infirmity and although they need few medical services, they cannot provide for themselves.

Supervised living arrangements, perhaps more so than any other category, tend to be physically segregated from the remainder of the living arrangements. This seems to be true regardless of the overall structure of the community. The pattern is repeated in communities housed in high-rise buildings, rural campus settings, as well as those which are housed in several small or low-rise buildings.

There is undoubtedly a strong economic incentive for developers to concentrate in a single location, the residents who require the most services. In addition, there are also regulatory reasons, related to safety, accountability, and liability, that dictate some physical separation between areas where residents are supervised and the surrounding areas where they are not.

There is, however, another strong reason for the almost universal segregation of the nursing home components of these communities. In one location, an administrator reported that

They like having it (the nursing home) here but none of them wants to look at it. They all have friends there and they visit all the time, some visit every day, but I think it depresses them to look at it. They all like knowing that it is here, but it just wouldn't do to have it in the main building.

Each of the living arrangements, whether clearly segregated physically or not, carries with it a gross

assessment of presumed functional ability. To the extent that the different living arrangements are in fact segregated, the functional expectations of the residents attach to the housing types as well. Thus, there are certain functional expectations that are associated with assisted living and that are also associated with living in a congregate living facility.

Similarly, just as the term "independent living" suggests a type of housing that is more or less private and self sufficient, so too the term "apartment living" suggests a living arrangement that is not dependent upon outside services.

One implication of this is that there is a hierarchy from which an individual's level of functioning is judged based upon the individual's place of residence. Put another way, the actual physical structure in which one lives may be taken as rough estimate of one's functional ability.

These rough estimates appear to be shared by the residents and the officials of the organizations alike. In broad terms, certain living arrangements carry with them certain expectations of functional ability such that the arrangements generally thought of as "assisted" carry with them the expectation that those residents who live in them will require certain types of services.

The practical impact of this is that, because of the relationship that exists between housing type and living

arrangement, service delivery may become institutionalized within housing types and only remotely reflect the diversity of needs of the resident population.

The relationships discussed above also have an impact on the continuum of care as a conceptual tool. By rearranging the elements of service and housing types within the context of living arrangements, the continuum of care can be graphically presented as it is in Figure 4.

Beyond its usefulness as a means to a more complete understanding of continuing care retirement communities, the conceptualization of a continuum of care as presented in Figure 4 suggests itself as a potentially rich direction for further research. One area, that might be especially interesting to gerontologists and sociologists alike, involves the meaning that residents attach to the concept of a continuum of services. If functional ability is perceived to be related to the physical space one occupies, then the residents might judge the health of friends, and even of themselves, based upon where within the community they find themselves living, rather than on a more objective assessment of functional ability.

If this is indeed the case, elderly residents may adopt behaviors and attitudes that they deem appropriate to a particular housing type, irrespective of the objective reality. Consequently, the criteria for placement within a continuing care community become more important.

Costs of Living In Florida's Continuing Care
Retirement Communities

Excluding Pine View Village, about ninety-two percent (37) of the communities responding to the questionnaire reported that they charged an entrance fee. The fact that the remaining eight percent (3) operating as licensed continuing care retirement communities do not charge entrance fees would tend to support our suggestion that the definition used to describe these communities should be related to the actual services offered and not rely solely on the financial arrangements between the community and the residents.

Table 9 presents the data on the entrance fees and monthly rental fees charged by these communities.

Table 9

The Fee Structure of Florida's Continuing
Care Retirement Communities

	Mean	Maximum Value	Minimum Value	Standard Deviation	n
<hr/> Fee Type:					
Entrance Fees:					
Lowest	\$23,203	\$45,500	\$3,300	\$13,282	37
Highest	\$66,390	\$128,000	\$10,000	\$32,761	37
Monthly Rental Fees:					
Lowest	\$515	\$850	\$88	\$157	37
Highest	\$1,014	\$2,600	\$264	\$435	37

As is noted in Table 9, entrance fees vary widely among the communities. Because each community usually offers several different types of housing, they have several different levels of entrance fees base upon the housing type required at first residence. Thus, the lowest entrance fees charged range from a low of \$3,300 to a high of \$45,500. The mean value is \$23,200 ($s = \$13,282$). The highest fees, on the other hand, range from \$10,000 to \$128,000 with a mean value of \$66,390 ($s = \$32,761$).

It is clear that the entrance fees are related to the types of housing arrangement requested by the potential resident. Generally, the higher the entrance fee the better, in a qualitative sense, the accommodation. However, there is also a quantitative element in the costs of living in these communities. This is usually reflected in the monthly fees charged to residents. Here, a generalization would be that the higher the monthly fees, the better, in a quantitative sense, the services. Put another way, in a broad sense, entrance fees are related to the quality of housing type chosen, and monthly fees are related to quantity of support services delivered. The relationship is by no means perfect, but it is clear that it does exist.

Table 9 also presents the data on the monthly fees charged to the residents. Again, there are different levels of costs for different levels of services. In addition, for couples occupying the same dwelling unit,

most communities charge an amount that is more than the single occupancy rate but less than double that rate. For the purposes of comparison, the amounts shown here are the single rates.

The reported minimum monthly charges range from \$88 to \$850 per month. The mean is \$515 and the standard deviation is \$156.80. The maximum monthly charges range from \$264 to \$2,600 with a mean value of \$1,014 and a standard deviation of \$434.

It is obvious from the above data that continuing care retirement community life is not generally available to all elderly who may need it. Even if entrance fees can be met by the sale of a home, which is the usual way such expenses are financed, the monthly fees can quickly deplete any remaining amount. And, that alone might be enough reason for some elderly to remain in their more traditional living arrangements.

In a very real sense then, the elderly person who sells her or his home in order to move into a continuing care retirement community is gambling that whatever financial resources remain will be enough to pay the monthly charges and living expenses for an indefinite period of time. To a person seventy-five years old and with few prospects for locating new sources of income, this may be too risky a proposition.

In fact, a study conducted by the University of Pennsylvania in 1981 (Winklevoss, 1985) estimated that between fifteen percent and twenty-five percent of the

current population over age seventy-five could afford the costs of continuing care. That means that, based upon current census estimates, as many as 2.8 million people over the age of 75 could afford continuing care. The same study estimated that in 1981 only about fifty thousand people over seventy-five actually lived in continuing care retirement communities (p. 59). The larger question, then, is not can the elderly afford continuing care, but rather, why so few individuals choose this lifestyle.

It is clear that in some CCRCs, absent any widely available subsidies, the problem is directly related to financial resources. This is underscored by the fact that in one instance, the chief officer of one of the more luxurious of these communities stated that the simple rule by which he judged financial ability was this: if the potential resident has a net worth of less than four times the entrance fee, then he or she is not admitted. That would mean that a potential resident of this particular facility, assuming the most expensive and luxurious arrangement possible, would have to have a net worth in excess of five hundred thousand dollars even to be considered for admission.

Summary

There are three closely related issues that are the defining characteristics of continuing care retirement communities. The housing type, living arrangement, and service types must all be considered if a clear picture of these communities is to emerge.

Housing types refer to the actual physical structures located within any of these communities. Generally, there are at least two common housing types with local variations accounting for several other possibilities. First, most of these communities are housed in at least one multi-story building with numerous apartment units on each floor. Second, where there is a nursing home component, it is usually physically separated from the other units.

In some other communities, an Adult Congregate Living Facility may be located in the main building or it may be housed separately. In addition, in some cases, all of the facilities are located in a single building and are segregated, if at all, by floor or by some other classification (i.e., "wing").

Living arrangements refer to the actual level of care, or intensity of care, that is required by a particular resident. The type of retirement communities in this study generally offer only three living arrangements; independent, assisted, and supervised.

Finally, service type refers to the extent of services that the residents require. Generally, continuing care retirement communities offer three distinct types of services to their residents.

Personal care services are services related to what gerontologists call the "activities of daily living" and include such widely diverse services as management of medication and personal hygiene.

Homemaker services are generally related to the daily household tasks that must be performed, such as laundry, shopping, and meal preparation.

A final category of service type is transportation. Basically, as the label suggests, this type of service involves physically transporting the elderly resident to and from places that he or she would not otherwise be able to go. Generally, this includes trips to the physician and pharmacist as well as planned recreational "outings."

It is suggested that these three elements are related in that certain living arrangements imply certain housing types and service types. It is also suggested that the continuum of care, if it is to remain a viable conceptual tool, must be expanded to take account of the differences in these three variables.

Generally, the costs of living in a continuing care retirement community in Florida vary widely both in terms of the entrance fees and the monthly fees. One thing, however, is very clear. Except for the least expensive of these communities, that is those that are subsidized or that offer only minimal services, the arrangements offered are not available to elderly people of modest resources.

CHAPTER SEVEN
THE POPULATION CHARACTERISTICS OF FLORIDA'S
CONTINUING CARE RETIREMENT COMMUNITIES

The characteristics of those groups of elderly people who choose non-traditional or "alternative" living arrangements have been an important, if not primary, focus of several research efforts. Generally, since living in an owner occupied single-detached dwelling is by far the most common housing arrangement in this country--even among the "old-old," those who live in other arrangements are viewed as having special needs or personal preferences that dictate a different, and usually more supportive, living environment. Studies by Streib, LaGreca, and Folts (1986), and Streib, Folts, and Hilker (1984) suggest that those who choose non-traditional living arrangements tend to fall into one of two groups that can be divided, more or less, on the basis of health concerns.

The first group tends to be younger, in better health, and in a better financial position than the general population of elderly people. They tend to choose their living arrangements based upon the overall lifestyle that a particular community offers. Specifically, this group tends to place emphasis on social programs within the living arrangement and on the array of recreational

services and facilities that are available. To these individuals, the "leisure lifestyle" is important.

The second group tends to be older and more frail in terms of personal health. These individuals tend to seek living arrangements with support services aimed at health related problems. Although many of these people do not need support services at the time they first move into a non-traditional living arrangement, they tend to be concerned that at some time they, or their spouses, will indeed need such services.

From these two studies and others, for example; Hunt, Feldt, Marans, Pastalan, and Vakalo (1984), and Lawton (1981), there has emerged a picture of the elderly resident of a retirement community, and indeed other so called "alternative living arrangements", as one who not only takes an active and calculating role in choosing his or her retirement housing, but as one who is generally satisfied with the services that are provided once the decision to move has been made.

Far from being the elderly "ghetto" envisioned by some, most notably Maggie Khun of the Gray Panthers and, to a lesser extent, Jacobs (1974), those elderly who choose to live in non-traditional living arrangements may in fact be happier with their new lifestyle than those who choose to remain in their more traditional housing arrangements.

To be sure, there are wide variations in the quality of non-traditional housing arrangements, just as there are

in traditional housing arrangements. And, it should be everyone's concern that both elderly and younger people alike have adequate and safe housing. But, one of the important findings of the study by Streib, et.al. (1986) was that while retirement communities as a group cannot all be characterized as luxurious "country clubs" for affluent older people, it is just as inaccurate to categorize them as "ghettos" where desperately poor older people live lives of meaningless isolation, far from family and friends.

The issue of lifestyle satisfaction is indeed a complex one involving a wide array of factors including personality, health, financial situation, family situation, friendship patterns, and many other complex phenomena, that are quite beyond the scope and intent of this research. The issue is mentioned here only to underscore the fact that the vast majority of the elderly people who live in non-traditional housing arrangements do so because they have chosen to do so. And that decision is based upon their personal interpretation of their overall needs and an assessment of their ability to satisfy those needs.

The interaction of social phenomena that produces a population of elderly people who have both the desire, the good health, and the financial resources to move into a retirement community or other non-traditional housing arrangement, also acts to shape the types of housing

arrangements that are available. And, the recent emphasis on issues related to the elderly is adequate evidence of their influence as consumers.

As the studies above imply, the power of the elderly as consumers, real or potential, can be a major factor in shaping just what services and housing arrangements are offered. Reduced to its simplest form, and removing whatever altruistic motives might be involved, competition for resident's dollars among developers of retirement communities has insured that the elderly, as a group, have extraordinary power to shape just what these facilities offer them.

As mentioned in Chapter One, the development of continuing care retirement communities was the direct result of elderly people's efforts to expand the service components of retirement communities to include health related services. In their criticism of previous research involving retirement communities, Streib, LaGreca, and Folts (1986) call attention to the interaction between elderly people and developers of retirement communities in shaping the character of the modern retirement community.

What retirement community developers have done that social scientists have not done, is to judge accurately and respond adequately to the preferences and power of elderly persons as consumers. (p.102)

This is not to suggest that the efforts of these elderly people were intentionally directed at producing a new housing arrangement. Quite the contrary, there is no

reason to believe that the influence of the elderly as consumers was directed at anything beyond meeting their immediate personal needs for health related services and, in that sense, the developers who attempted to meet the needs of a potential market were far more influential in producing the modern continuing care concept.

It is suggested, however, that the influence of the elderly populations of these communities represent a powerful source of pressure to innovate, and that the characteristics of the resident population have a profound impact upon the "personality" of a retirement community even if that influence is limited to the immediate surroundings.

Whether one subscribes to a point of view that multi-level care retirement communities were produced by careful marketing considerations, or one that views them as the more or less random result of resident initiated organizational innovation and evolution, the conclusion is essentially the same. Namely, that the various types of retirement communities are a direct result of interaction between potential residents, who have special needs, and developers, who can, whatever their motivation, meet those needs.

As mentioned in the previous chapter, Pine View Village is somewhat unique among continuing care retirement communities both in terms of its development and its adaptation to a changing operating environment.

However, it has been organizationally stable for at least the past decade and it adopted the "continuing care concept" in the 1950s. Additionally, since the average age of the residents is about 80 years old, it is reasonable to assume that almost all, if indeed not all, of the current residents moved to the community after it had adopted the continuing care concept.

For these reasons, it is reasonable to assert that, except for differences related to the personal preferences and financial ability of the residents, those who have chosen to live in Pine View Village are probably representative of the type of elderly persons who choose life care as an alternative living arrangement.

As with any organizational case study, the typicality of the focal organization must remain largely a matter of faith, based upon the researcher's knowledge about other similar organizations. In the present study, data collected at Pine View Village, as a case study, were expressly intended to provide a foundation for further research efforts and to suggest directions in which organizational issues could be pursued. In that sense Pine View Village has served its purpose well.

Pine View Village has proven to be an exceptionally rich source of data and the characteristics of the resident population have suggested several categories of organizationally relevant information that should be pursued on a much larger scale than is possible here.

Among these categories are such issues as resident turnover rates and waiting list composition, information about the ages of the residents and death rates, and the time periods between admission to the community and a residents admission to the nursing facility. All of this information was made available and is summarized below.

Pine View Village: Demographic
Characteristics of the Population

Pine View Village currently houses 438 elderly residents living in six different housing arrangements. As mentioned before, the community also serves families and children but these facilities are generally located in separate areas of the community and are both organizationally and physically distinct from the facilities directed toward the elderly residents. For our purposes here, except where noted, only elderly residents are counted in the calculations.

Table 10 presents a compilation of the population characteristics of Pine View Village from 1978 to 1986. Data for 1986 includes only information through April of that year. There are three sets (rows) of data for each of the six housing arrangements.

The first, labeled row "a", is a census count of the actual number of residents in a particular living arrangement for a particular year. These data are based on the actual average monthly population counts and reflect a simple yearly average of the average monthly counts. The

Table 10 Census and Percent Change in Population in Pine View Village: 1978-1986.

Housing Type	1978-1986									
	1978	1979	1980	1981	1982	1983	1984	1985	1986	Mean CHANGE
Single Detached	(a) (16)	(20)	(26)	(27)	(36)	(38)	(49)	(45)	(55)	(34.7)
	(b) --	+4	+6	+1	+9	+2	+11	-4	+10	+5
	(c) --	+25%	+30%	+4%	+33%	+6%	+29%	-8%	+22%	+18% (+244%)
Mobile Homes	(a) (40)	(42)	(57)	(61)	(58)	(57)	(57)	(59)	(59)	(54.5)
	(b) --	+2	+15	+4	-3	-1	0	+2	0	+2
	(c) --	+5%	+36%	+7%	-5%	-2%	0%	+4%	0%	+6% (+48%)
Terrace Apartment	(a) (40)	(42)	(40)	(40)	(31)	(34)	(37)	(34)	(34)	(36.9)
	(b) --	+2	-2	0	-9	+3	+4	-3	0	-1
	(c) --	+5%	-5%	0%	-23%	+10%	+9%	-8%	0%	-2% (-15%)
Apartment A	(a) (96)	(97)	(93)	(95)	(93)	(91)	(90)	(90)	(83)	(92.0)
	(b) --	+1	-4	+2	-2	-2	-1	0	-7	-2
	(c) --	+1%	-4%	+2%	-2%	-2%	-1%	0%	-8%	-2% (-14%)
Apartment B	(a) --	--	--	--	(105)	(103)	(104)	(107)	(103)	(104.4)
	(b) --	--	--	--	--	-2	+1	+3	-4	-1
	(c) --	--	--	--	--	-2%	+1%	+3%	-4%	-0% (-2%)*
Nursing Facility	(a) (100)	(100)	(100)	(100)	(100)	(105)	(100)	(103)	(104)	(101.3)
	(b) --	0	0	0	0	+5	-5	+3	+1	+1
	(c) --	0%	0%	0%	0%	+5%	-5%	+3%	+1%	+1% (+4%)
Total	(a) (292)	(301)	(316)	(323)	(423)	(428)	(437)	(438)	(438)	(377.3)
	(b) --	+9	+15	+7	+100	+5	+9	+1	0	+18.3
	(c) --	+3%	+5%	+2%	+31%	+1%	+2%	+0%	0%	+6% (+50%)

a = Population Census.

b = Net Change in Population Census from Previous Year.

c = Percent Change in Population from Previous Year.

* Figures for Apartment B were calculated from 1982.

row labeled "b", represents the net change in the census from the year immediately preceding a given year. And, row "c" represents the percent change in population of a particular year based upon the number of residents in the previous year.

The column labeled "mean" is a simple average of the data displayed in each of the rows. For example, in 1985 there were forty-five individuals living in single detached houses in Pine View Village (row "a"). This was a net loss of four people (row "b") from 1984, and represented a loss of -8.2% of the 1984 population (row "c"). Additionally, the mean population of single detached homes was 34.7 each year from 1978 to April of 1986 and the rate of change has been an additional 4.9 people per year or +17.6% per year.

The final column of Table 10 compares population characteristics of 1978 to those of 1986 and reports the actual number change and the percent change in the population. Thus, for the example used above, the 1986 population of single detached homes represents a net gain of 39 people over the population in 1978. This is a growth of +243.8% in that particular living arrangement.

It can be concluded, based upon the data in Table 10, that the period 1978 to April, 1986 was characterized by a general growth in the population of the community as a whole. It should be noted that the numbers represent all persons in a particular category such that couples are

counted as two separate people. Since the various levels of independent living are directed specifically at couples, it is important to remember that here we are discussing actual persons and not merely housing units.

Thus, the data indicate that in 1978 there were sixteen individuals living in single detached housing units--not sixteen housing units. This is particularly important when considering the more independent living arrangements since those who choose to live in single detached houses or mobile homes are more likely to be currently married.

Compounding the problem is the fact that when an established single detached home becomes available for new residents, it is likely that the space was created by a widow moving into a more supportive environment. In the case of the single detached homes and the mobile homes, it is particularly important not to confuse increases in the population with expansion of the physical facilities. Put another way, if all single people in a community were replaced by couples, the result would be a substantial increase in the population with no increase in the physical facilities. The actual increase would, of course, depend on the number of couples who already live in a community, but the point should be clear.

Despite the possibility of misunderstanding, the single best indicator of the size and extent of continuing care retirement communities is the actual number of

individuals it serves. Additionally, since accounting for community service levels is based on the actual delivery of services to individuals, not couples, the impact of this phenomenon, for our purposes at least, is not critical.

For that reason, except where noted, whenever the resident population of a particular community is discussed, the actual number of individuals, regardless of their relationships, will be used. It remains important, however, to note that one component in the percent change of the population is the replacement of single people by couples who live in one dwelling unit.

Perhaps the most striking feature of Table 10 is the 244% increase in the population living in single-detached houses and the almost 50% increase in persons living in mobile homes. True, the increases were spread out over the eight years covered by Table 10, but increases of this size are clearly an indication of more or less rapid expansion. In fact, the increase in the population of single detached houses has been about 18% per year since 1978. This expansion reflects an organizational commitment to attracting younger and healthier couples to the community.

Another important event, clearly displayed in Table 10, was the addition of Apartment B in 1982. This had the immediate impact of increasing the resident population by about 31%. If the impact of Apartment B is removed from the calculation, the population of Pine View Village would

have grown only about 3% per year from 1978 to 1986 instead of the almost 6% rate reflected in the table.

Another interesting set of facts illustrated in Table 10 is the data for the community as a whole located in the final three rows of the Table. Particularly interesting is the fact that the population averaged 377.3 people for each of the years with about eighteen (5.6%) new residents being added each of the years. By removing the impact of the opening of Apartment B, there was a net increase of only forty-three residents between 1978 and April, 1986. Since the single detached houses and the mobile homes together accounted for fifty-eight new residents and the nursing home accounted for four, the existing apartments actually lost nineteen residents in the same period.

One indicator of the stability of the resident population is the number of admissions that occur each year. Since Pine View Village has waiting lists for all its facilities the number of new admissions is a satisfactory, if only rough, indicator of resident turnover.

Table 11 displays information on the raw number of admissions, by year, from 1978 to 1985. Again, there are three sets of numbers for each category of housing. The row labeled "a" is again the actual census of the population. Row "b" is the actual number of admissions during a particular year and row "c" represents the number of admissions as a percentage of the actual population for

Table 11

Admissions to Pine View Village as a Percentage of the
Resident Population: 1978-1985.

Housing Type	1978	1979	1980	1981	1982	1983	1984	1985	Average
Single Detached	(a) 16 (b) 7 (c) 44%	20 5 25%	26 9 35%	27 8 30%	36 7 19%	38 11 29%	49 6 12%	45 4 9%	32.1 7.1 25%
Mobile Homes	(a) 40 (b) 2 (c) 5%	42 0 0%	57 16 28%	61 10 16%	58 9 16%	57 5 9%	57 6 11%	59 6 10%	53.9 6.8 12%
Terrace Apartments	(a) 40 (b) 6 (c) 15%	42 5 12%	40 7 18%	40 0 0%	31 2 7%	34 6 18%	37 1 3%	34 1 3%	37.3 3.5 9%
Apartment A	(a) 96 (b) 11 (c) 12%	97 5 5%	93 7 8%	95 6 6%	93 3 3%	91 5 6%	90 7 7%	90 4 4%	93.1 6.0 6%
Apartment B	(a) -- (b) 0 (c) --	-- 0 --	-- 0 --	-- 105* --	105 39 37%	103 18 18%	104 10 10%	107 14 13%	104.8 20.3 19%
Nursing Facility	(a) 100 (b) 11 (c) 11%	100 8 8%	100 29 29%	100 21 21%	100 9 9%	105 17 16%	100 13 13%	103 6 6%	101.0 14.3 14%
Total	(a) 292 (b) 37 (c) 13%	301 23 8%	316 68 22%	323 45 14%	423 69 16%	428 62 15%	437 43 10%	438 35 8%	369.8 47.8 13%

a = Census of Current Resident Population.

b = Admissions.

c = Admissions as a Percentage of Population Census.

a given year. For example, in 1978 there were seven new admissions to the single detached homes and this represented 43.7% of the established population of those homes in 1978.

The final column of Table 11 presents the simple averages and is intended as a summary indicator of resident turnover. Again, using the single detached category as an example, new admissions to the single detached homes in Pine View Village represented about 25% of the population of that living arrangement each year from 1978 to 1985. Put another way, about seven new residents per year were admitted to this category of housing arrangement. ..

The number of admissions to Pine View Village is an indicator of resident turnover if, and only if, the facility is operating at, or very near, capacity and then only to the extent that expansion of the facilities does not occur. Only then is the addition of new residents dependent upon current residents vacating their dwelling units. The addition of new facilities, such as the construction of Apartment B, tends to inflate the estimates of resident turnover because new people are added but no established residents must leave to make room for them.

For that reason, data from Apartment B were not used in the summary calculations of the total percentages appearing in the final column and row of Table 11.

However, the data for that facility are included in the body of the Table so that a visual comparison can be made.

Perhaps the best summary indicator of resident stability is the final cell of Table 11. Assuming that the facility is operating at full capacity about 13% of the total population of Pine View Village was replaced each year between 1978 and 1985. Although the absolute number (48) seems small, the fact that almost 13% of the residents have to be replaced each year means that the recruitment of potential residents and the maintenance of waiting lists becomes an important element of the organizational structure.

The assumption of full capacity is crucial to the idea of resident turnover if the number of admissions is to be a reasonable indicator. In fact, full capacity has been the general trend in Pine View Village, at least since 1978. Table 12 contains information about the actual number of persons on waiting lists for the various housing types as well as the ratio of the number of people on the waiting list to those who already reside in a particular housing arrangement.

In this Table the effects of Apartment B are included because even before the facility was opened, there were people on a waiting list. The percentages for Apartment B, however, are not calculated and do not show up in the summary calculations until after the facility actually opened. Again, the data for Apartment B are included in the body of the table for visual comparison.

Table 12 Waiting Lists at Pine Pine View Village as a Percentage
of the Resident Population: 1978-1985.

Housing Type	1978	1979	1980	1981	1982	1983	1984	1985	Average
Single Detached	(a) 16 (b) 1 (c) 6%	20 1 5%	26 6 23%	27 0 0%	36 1 3%	38 -- --	49 -- --	45 15 33%	32.1 4.0 12%
Mobile Homes	(a) 40 (b) 14 (c) 35%	42 16 38%	57 2 4%	61 13 21%	58 12 21%	57 18 32%	57 20 35%	59 22 37%	53.9 14.6 28%
Terrace Apartments	(a) 40 (b) 58 (c) 145%	42 43 102%	40 70 175%	40 79 198%	31 42 136%	34 47 138%	37 65 176%	34 86 253%	37.3 61.3 165%
Apartment A	(a) 96 (b) 102 (c) 106%	97 105 108%	93 149 160%	95 154 162%	93 94 101%	91 59 65%	90 107 119%	90 133 148%	93.1 112.9 121%
*Apartment B	(a) -- (b) 0 (c) --	-- 37 --	-- 75 --	-- 115 --	105 99 94%	103 102 99%	104 126 121%	107 141 132%	104.8 117.0 112%
Nursing Facility	(a) 100 (b) 38 (c) 38%	100 50 50%	100 44 44%	100 48 48%	100 71 71%	105 52 50%	100 31 31%	103 49 48%	101.0 47.9 47%
Total*	(a) 292 (b) 213 (c) 73%	301 252 84%	316 346 110%	323 409 127%	423 319 75%	428 278 65%	437 349 80%	438 446 102%	369.8 326.5 89%

a = Census of Current Resident Population.

b = Number of Persons on Waiting Lists.

c = Waiting Lists as a Percentage of Population Census.

* Data for Apartment B are not included in the summary calculations.

The simple averages in the final column of Table 12 indicate that with the exception of the waiting lists for the single detached housing units (15.42%) and mobile home units (31.2%), all of the various living arrangements had waiting lists that were at least about 50% the existing populations. In some cases the waiting list was equal to as much as 146% of the population.

The final three cells in the Table indicate that when Pine View Village is considered as a whole, the average number of people waiting to be admitted to the community was about 327 each year between 1978 and 1985. Put another way, the average of the total number of people waiting to be admitted to the community was equal to about 92% of the average resident population for each of the past nine years.

Another important indicator of resident turnover is the number of persons who leave the nursing home facility. These people represent an especially important group because of the nature of the facility. Put bluntly, there are essentially only two ways for a person to leave a nursing facility--either they are discharged or they die. In the former case, either they leave the community entirely, or they are absorbed back into it at a level that is less supportive than the nursing facility.

Table 13 presents data on discharges and deaths in the nursing facility of Pine View Village for the years 1980 through 1985.

Table 13 Deaths and Discharges from the Nursing Facility
at Pine View Village: 1980-1985.

	1980	1981	1982	1983	1984	1985	Average
Number of Deaths	28	26	26	30	21	20	25.2
Number of Discharges	19	29	17	20	34	17	22.6
Ratio of Discharges to Deaths	.68	1.1	.65	.67	1.6	.85	
Average Age at Discharge	81.6	86.6	80.7	82.1	79.9	79.7	
Average Age at Death	92.1	84.9	87.4	86.2	87.8	86.3	

When a resident of the nursing home component of a continuing care retirement community dies or leaves the community entirely, the result is that, in effect, two spaces are created. First, the space in the nursing facility is available for someone in need of such services from within the community. Second when a current resident moves into the nursing facility, his or her dwelling unit becomes available for those on the less supportive waiting lists. Conversely, when a person is discharged to the less supportive living arrangements, only one space is created, and in fact, placement problems may arise from the lack of less supportive space. The result is that much time and effort is spent in attempting to match the needs of the residents with the spaces that are available.

Even this task would be greatly simplified if there existed a true continuum of care. However, as noted before, what is analytically presumed to be a continuum of care is, in reality, discrete points of increasing support grouped into several major categories with wide gaps between groups of services. And, as pointed out in the discussion of Figure 4, there are "breaks" in the continuum such that the various kinds of care offered on either side of the breaks are fundamentally different.

The problem arises when an individual crosses the "breaks" in the continuum of care and space must be found in a less supportive environment on short notice. Although crossing the "breaks" at any juncture along the continuum

produces uncertainty within the organization, the most serious problems occur when a resident is discharged from the nursing facility back into the community.

The reason for this is that the options of the resident are usually limited by his or her functional ability and at some point a subjective judgement was made as to the probability of that individual being able to return to a less restrictive housing environment. If the judgement of the organization is that the resident will not return, there may no longer be space for that individual.

Although discharges are an important, and much more auspicious, factor in the stability of nursing home populations one should expect that the number of deaths in a nursing facility would represent a rather substantial portion of those who leave the facility. This is the case at Pine View Village.

As Table 13 indicates, the data for the average age at discharge or death and the ratios of discharges to deaths suggest that those who die in the nursing facility are very old and that the average number of discharges (22.7) for the years 1980 through 1985 is slightly higher than the average number of deaths (22.0) for the same period.

Other than the initial judgment of whether a particular resident is likely to need nursing care, perhaps the most critical calculations made by those who

establish continuing care retirement communities involves an assumption about the number of years between the time a resident is admitted to the community and the time he or she will need nursing care services.

The fact that the total number of spaces in any nursing facility is limited by the regulatory process and is thus practically inflexible, in the short run at least, means that calculating the amount of time between acceptance as a resident in the community and admission to the nursing facility is crucial in predicting the number of people who will need nursing services.

Since the main attraction of any multi-level care facility is precisely that multiple levels of care are provided, and since there is always what we have called a reasonable expectation of life-long care, those who operate these communities must assume that the residents anticipate needing all levels of care, including the nursing services. For that reason, accurate prediction of the time involved in moving along the continuum of care is an essential element in the continued and successful operation of these facilities.

Table 14 presents data for the years 1980 to 1985 indicating the length of time between being admitted as a resident to Pine View Village, in years, and first admission to the nursing facility.

The numbers in parentheses indicate the total number of admissions to the nursing facility from each of the

Table 14 Average Length of Residence Between Admission to Pine View Village and First Admission to the Nursing Facility: 1980-1985.

Housing Type	1980	1981	1982	1983	1984	1985
Single Detached	(a) 10.1 (b) (1)	-- --	6.4 (3)	11.1 (2)	0.6 (2)	3.8 (2)
Mobile Home	(a) 4.6 (b) (2)	8.4 (3)	9.0 (3)	5.1 (4)	18.5 (2)	6.4 (4)
Terrace Apartments	(a) -- (b) --	3.9 (4)	3.7 (2)	3.9 (1)	4.7 (4)	5.5 (1)
Apartment A	(a) 5.2 (b) (17)	8.3 (20)	9.0 (18)	9.3 (10)	7.6 (25)	12.9 (11)
Apartment B	(a) -- (b) --	-- --	0.7 (5)	1.6 (10)	2.4 (10)	3.7 (7)
Total	(b) 20	29	31	27	43	25

a = Number of Years

b = Number of Persons

other living arrangements. The other numbers represent the length of time, in years, between first residency and admission to the nursing facility for each of the other living arrangements. Although the actual numbers of admissions are small and some who become ill move out of the community entirely, Table 14 provides some indication of the relative health of those who choose this type of retirement community.

For example, the average time between first residency and first admission to the nursing facility for residents of the single detached dwellings has been 6.37 years for the years 1980 through 1985. For the same group, the time between first residency and permanent admission to the nursing facility is 5.93 years. Again, although the numbers are small and not all who need nursing services obtain them within the community, the general and expected pattern of those in the lowest levels of supportive housing remaining in the community for longer periods of time is apparent.

Table 15 presents the data for the average length of time between first admission to Pine View Village and permanent admission to the nursing facility. Again, the numbers are small but note that, generally, the numbers are not much different from those in Table 14.

As the Tables discussed above suggest, Pine View Village is essentially operating at capacity with generally long waiting lists for each of its facilities.

Table 15 Average Length of Residence Between Admission to Pine View Village and Permanent Admission to the Nursing Facility: 1980-1985.

Housing Type	1980	1981	1982	1983	1984	1985
Single Detached	(a) 10.0 (b) (1)	-- --	-- --	9.3 (1)	0.8 (1)	3.8 (2)
Mobile Home	(a) 6.8 (b) (1)	-- --	-- --	6.0 (2)	18.6 (2)	8.3 (3)
Terrace Apartments	(a) -- (b) --	6.8 (2)	9.0 (3)	-- --	-- --	-- --
Apartment A	(a) 4.9 (b) (7)	7.2 (3)	8.4 (14)	11.7 (6)	3.8 (8)	13.8 (6)
Apartment B	(a) -- (b) --	-- --	-- --	1.8 (3)	2.4 (5)	3.6 (6)
Total	(b) 9	6	19	12	16	17

a = Number of Years

b = Number of Persons.

It would therefore seem to be a reasonable assumption that the demands placed upon the organization by an aging and changing resident population would be a relatively simple matter. This however, is not the case.

The situation illustrated for Pine View Village points to one of the primary weaknesses of conceptualizing continuing care communities in terms of a continuum of care. It is deceptively attractive, and not uncommon, to visualize the concept of a continuum of care as, more or less, a tube which is plugged at one end, and into which healthy, relatively young, and active retired people enter at the open end and very old, very frail, inactive people who are waiting to die accumulate at the plugged end.

Although it would be difficult to imagine a situation where this analogy would be adequate, it is obviously inadequate in the case of continuing care communities, if for no other reason than the simple fact that residents enter a continuing care community at all levels of support. And, it is not only those in the most supportive levels that die or leave the community. In addition, although clearly an attempt is made to select relatively healthy individuals for admission, those on the waiting lists are aging and becoming more frail too.

The "tube" analogy is thus not adequate to explain the case of continuing care communities and the organizational decisions that are required for the continued survival of these communities are vastly more complicated than this analogy would permit.

For example, the population of Pine View Village generally consists of what Neugarten (1975, p. 9) has called the "old-old." The ages of the residents and the average ages and gender of those on the current (1986) waiting lists for the various facilities in the community are compared with similar data from the current resident population in Table 16.

As can be seen from the data displayed in Table 16, the ages of those on the waiting lists, while younger, are clearly not substantially different from the current population figures. This produces a situation where the organization must devote much energy to maintaining current information on those who have applied for admission.

Given the age characteristics suggested by Table 16, and in light of the discussion on the relationships between housing types and service levels, the more supportive the living arrangement, the more likely it is that when a vacancy occurs, the potential residents on the waiting list may in fact need a more supportive environment than the one they applied for in the first place. This added dimension of uncertainty requires that the predictive mechanisms of these organizations be well developed since they are very important to the overall survival of continuing care communities.

Table 16 Average Ages, Gender, and Sex Ratios for Residents
Now Living in Pine View Village.

Housing Type	Average Age	Gender		Sex Ratio (Female:Male)
		Male	Female	
Single Detached	75.7	29%	71%	2.4:1
Mobile Home	76.6	42%	58%	1.4:1
Terrace Apartments	78.8	29%	71%	2.4:1
Apartment A	80.1	8%	92%	11.5:1
Apartment B	82.2	17%	83%	4.9:1
Nursing Facility	85.8	19%	81%	4.3:1
Total		24%	76%	3.2:1

Characteristics of Florida's Continuing Care
Retirement Communities: Survey Data

In at least one important aspect, Pine View Village is unquestionably unique. The fact that the facility was established in the beginning years of this century places it second in terms of age among those communities responding to this study. In fact, only three communities in this study were founded prior to 1952. Those three communities, established in 1899, 1914, and 1919, are all affiliated with religious or fraternal organizations.

About half of the communities responding to the survey were established after 1975. And, except for the three that began operation before 1920, the other half were established between 1952 and 1975. This suggests that, even though continuing care retirement communities have existed in Florida for quite some time, their organizational structure and the elements that make up today's communities are rather recent developments. In fact, as is the case with Pine View Village, each of the other three "original" communities has undergone substantial change such that their present form is far removed from the original.

There are indications that this is true of the communities established in the early fifties as well. Fully sixty percent of the communities responding to the survey reported that they were first licensed after 1975. If 1965 is used as the base year, only twenty percent report that they were licensed before that year. Although

a number of facilities that were in operation in the 1950s are still in operation at this time, it is reasonable to assume that current licensure requirements have had a substantial impact on their operation and organizational form.

As discussed previously, continuing care retirement communities, regardless of whatever else they offer, consist of three basic kinds of living arrangements: independent, assisted, and supervised. Although both the intensity and the extent of the actual personal services offered by these communities are widely varied, all of them are delivered in one or more of these three settings. It is important to remember that, as far as state regulation is concerned, all that is required of a community to be classified as a continuing care retirement community is that it offer housing, personal services, and require an entrance fee.

Because of the rather broad regulatory classification of these facilities it is not surprising to find that there exists variation in the three basic living arrangements. Most, although not all, of the communities responding to the survey provided some form of independent living arrangement. Although this is as expected, it is by no means as obvious as it appears.

Take, for example, any of the categories of shared living arrangement previously discussed. Assisted living is usually taken for granted as the only form of housing

they offer. If any of these facilities were to require an entrance fee, and incidentally this very possibility has been discussed as a means to finance the construction of Adult Congregate Living Facilities, it would be categorized as a continuing care retirement community regardless of other regulatory classifications that might also apply.

About eighty percent (33) of the facilities responding to the survey reported that they offered some form of assisted living arrangement, usually provided in either an apartment or licensed Adult Congregate Living Facility, and about eighty-five percent (35) reported that they offered nursing home care (see Table 8).

Since continuing care retirement communities offer different levels of care depending on the needs of the individual residents, one of the most important duties of those in charge of the day-to-day operation of the community is to ensure that occupancy remains at predetermined minimum levels for all levels of care available.

From a purely organizational perspective, high vacancy rates can be just as injurious as overcrowding. In fact, there is probably much more latitude in finding care for those who need it when all available beds in the care facilities are occupied, than there is afforded by the financial reality of a facility with a high vacancy rate. Based on the recent implementation of statutory

regulations (Florida Code, 651.023) requiring that new facilities seeking licensure as continuing care retirement communities produce documentation of a fifty percent reservation rate before they are allowed to begin operation, it is probably the case that when these facilities fail it is because of underutilization not overcrowding or mismanagement of funds.

That vacancy rates present special problems to these communities may be inferred from the statutory attention given the issue. However, the situation is more complicated than even that suggests. It is not only the overall vacancy rates that are problematic, it is where the vacancies occur that is of critical importance.

In a general sense, vacancies in independent living arrangements are more important to the long term survival of these communities than are vacancies in the "care" living arrangements. Thus, it is not surprising to find that vacancies in independent living apartments usually attract more attention from the organization than do vacancies in the more supportive living arrangements. As one official indicated, "we can always find someone to move into the clinic (nursing home), the real trick is to get healthy people to move in in the first place."

There are five primary criteria used to determine the suitability of potential residents. In order of frequency of use among the communities in this study the five are: physical health status (95%), financial ability to pay for

services (85%), mental health status (78%), social skill level (41.5%), and religious affiliation (12.5%).

Given the importance of a younger, relatively healthy resident population, it is not surprising to find that physical health status is the single most frequently used criterion for judging the suitability of a potential resident. This is also related to the very concept of continuing care.

As mentioned above in the discussion of the "tube" analogy, correctly or not, both administrators and potential residents view continuing care in a processual sense. That is, it is believed that relatively healthy elderly people move into these communities and "move through" the various levels of care until, ultimately even the highest level of nursing care is no longer adequate and the resident either is admitted to an acute care hospital or he or she dies.

That the selection process is not taken lightly by the facilities is evidenced by the fact in about half of the communities, the decision to admit an individual is made by a formally established admissions committee. Generally, this committee is made up of all the top officers of the organization, at least one physician, at least one lawyer, and one or more representatives of the current resident population.

Even though the remaining half of the communities do not use the admissions committee process, in all of these

cases it is the top officials of the organization who make the final decision regarding admissions.

Another indicator of the importance of the admissions process is the fact that about seventy-three percent (30) of these communities reported that the admissions selection criteria were "formal" in the sense that they were written criteria presumably not subject to discretionary interpretation.

The financial status of the potential resident is listed as a criterion for admission by about eighty-five percent (35) of the communities in this study. This too is not surprising because of the entrance fee requirement and the general lack of subsidies. Among the remaining fifteen percent (6) that indicated financial concerns were not a criterion for admission, five of the six (83%) were affiliated with either a particular religious denomination or a fraternal organization. And, all of them were included in the 12.5% that reported membership in a particular religion or fraternal organization was a criterion for admission.

Thus, in communities where financial status is not a criterion for admission, it is likely that subsidies are available from a particular sponsoring religious denomination or fraternal organization and, based upon the interview data, it can be reasonably concluded that those who receive the subsidies occupy some special status with respect to the sponsoring organizations.

The physical layout of these communities as well as the surrounding areas is, as might be expected, widely varied. The communities located in urban areas tend to be in multi-story buildings with little, if indeed any, open areas. The rural communities, on the other hand, tend to be spread out over a wider area and housed in single-story or "low-rise" buildings.

Among the communities responding to the survey the actual size of the land upon which the communities are situated, that is the campus, ranges from a mere two acres to one community that is located on over nine hundred acres of land. Excluding the largest community from the calculation, the simple mean value for the size of the land upon which these communities are located is thirty-three acres.

Although that number is still a bit misleading because of the inclusion of two very large communities that are well over one hundred acres, fully fifty percent of the communities are located on between twenty and sixty acres of land.

As far as the overall size of the populations is concerned, Table 17 lists the capacity and actual sizes of the resident populations as well as a breakdown of the occupancy rates by level of care. Also included are the means and standard deviations as well as an indication of the total number of communities reporting.

Table 17
Capacity and Occupancy Rates of Florida's
Continuing Care Retirement Communities.

	Mean	Maximum Value	Minimum Value	Standard Deviation	n
Capacity:					
Independent Living	288.5	650	60	143.5	35
Assisted Living	79.3	550	10	109.0	33
Nursing Home	77.8	240	20	43.8	35
Total Capacity	376.6	894	64	208.0	41
Occupancy:					
Independent Living	234.3	550	31	123.6	35
Assisted Living	52.0	193	5	46.5	33
Nursing Home	71.3	200	16	39.1	35
Total Occupancy	302.7	793	60	170.6	41
*Occupancy Rates					
Independent Living	.81	1.0	.44	.19	35
Assisted Living	.65	1.0	.05	.20	33
Nursing Home	.92	1.0	.47	.12	35
Total Occupancy Rate	.799	1.0	.28	.29	41

*Occupancy Rates= Total Occupied Units / Total Number
of Units.

As Table 17 indicates, there is wide diversity in the capacities of these communities. The smallest of the communities studied has space for only sixty-four residents and the largest will accommodate almost nine hundred people. The actual numbers of occupied dwelling units are also included in Table 17 as are the occupancy rates for the three housing types. Although the Table indicates that the majority of these facilities are operating at a level well over fifty percent of their maximum capacity, there are some communities where occupancy levels are low indeed.

The communities have reported overwhelmingly that the occupancy trends since the establishment of these facilities can best be described as stable or increasing. Fifty-four percent (22) reported that occupancy trends have not changed substantially since operation began. Another thirty-two percent (13) reported that occupancy has increased and only fourteen percent (6) reported a decline in resident population. This, added to the information in Table 17, would suggest that the facilities with low occupancy rates are probably those that have either only recently begun operation, or those that recently established one of the three housing types listed here.

The age characteristics of these communities are interesting but not unexpected. Because of the nature of continuing care retirement communities, one would expect

to find what gerontologists call the "old-old." Table 18 displays the data on the age characteristics of the communities along with the means and standard deviations.

Table 18
The Age Characteristics of the Residents in
Florida's Continuing Care Retirement Communities.

	Mean	Mode	Maximum Value	Minimum Value	Standard Deviation	n
Oldest Resident	98	96	103	88	2.96	41
Youngest Resident	61	65	79	50	11.7	39
*Average	81.2	83	88	74	2.96	39

*The mean for the reported averages is a weighted mean that takes into account the individual population sizes. The other values for the average ages are simple counts of the reported values.

As Table 18 indicates, the average age of the residents in these communities ranges from 74 to 88. Since the raw data on the ages of all residents was unavailable, a weighted average based upon the total population size of a community and the reported average age of the residents in that particular community was calculated. The result shows that the weighted average age of the residents in continuing care retirement communities responding to the survey was 81 years old.

In the case of the oldest and youngest residents only the simple average is reported. Here, the average of the youngest resident ages reported is 61 and the average of

the oldest resident ages reported is 98. The ranges for these categories are given in Table 18.

Two cases were deleted from the calculations involving the youngest residents. In one of the cases, one spouse was in his or her early thirties and was allowed in the community only because the other spouse met the age restrictions. In the other case, a small child was adopted by her grandparents and was living in the community with them. Both of these cases involved persons living in independent arrangements.

The topic of age restrictions has been one of particular interest in recent years (see for example Eglit, 1985). By their very nature, age restrictions impose a homogeneity, based on age, on a particular group of people. Whether one views that as a positive protective device or as a negative discriminatory maneuver, the fact is that age restrictions are a part of the reality of retirement communities. In the case of these continuing care retirement communities, about seventy-five percent (31) report that they indeed have minimum age restrictions for potential residents. In general, a couple will satisfy the age requirement if only one of the spouses has attained the required age.

In these communities age restrictions range from a low of 55 years old to a high of 65 years old with 60 and 62 being common alternatives. The modal category is 65 years old, with almost thirty-two percent (13) of the communities reporting that age as the minimum allowed.

Almost as important as selection criteria is the issue of resident turnover. Not only are the absolute numbers important, but the reason is equally important. The communities responding to the survey reported that on average in the past year twenty-four residents left. The range was 1 to 110.

The respondents were asked to indicate the primary reasons for the residents departure. Ninety-five percent (39) of the communities reported that death was one of the primary reasons residents left the facility. This is quite expected given the ages and frailty of these individuals.

More interesting perhaps is the fact that about forty-four percent (17) of the communities reported that residents left because they had needs beyond what could be provided in the community. One encouraging note is the fact that only thirty-four percent (14) listed inability to meet financial obligations as a primary reason for elderly residents leaving the facility.

Summary

The elderly people who choose to live in alternative living arrangements are atypical in terms of the larger population of elderly people. It is true that the overwhelming majority of this nation's elderly people live in single-detached homes that they themselves own. Because of this, those who choose non-traditional, or alternative, living arrangements are perceived to have either special needs that cannot be provided for in a traditional

setting, or they have personal preferences that dictate a non-traditional lifestyle.

The latter group tends to be younger and less frail and, generally, they are the people who make up the populations of regular retirement communities. The former group, however, tends to be older and more frail. It is these individuals who are found in the continuing care retirement communities.

This is not to suggest that actual health concerns are the only reason elderly people choose this type of housing. Quite the contrary, the anticipation of a future need for the support services offered by these communities is often sufficient. So too, security, both in terms of the availability of health care and in terms of actual physical protection from those who prey on the elderly, is a powerful force in the decision to move to one of these facilities.

Generally, the residents of Florida's continuing care retirement communities tend to be in the group that gerontologists have come to call the "old-old." In fact, the weighted average age of the populations of the communities responding to this study was eighty-one years old.

The age characteristics alone imply that the populations of these facilities are largely females whose spouses have already died. That is indeed the case. However, the full impact of this is usually not fully

appreciated even by those who organize these facilities. For example, many of these communities profess to a preference for "younger" elderly people. In reality, of course, what they mean is "healthier" elderly people. But, it is just these "younger" or "healthier" people who are likely to still be married, and since most of the dwelling units in these facilities were designed for single occupancy, this type of living arrangement is not likely to attract large numbers of couples.

Thus, there is a pronounced conflict between the organizational desire to attract younger and healthier old people and the physical limitations of the buildings that house them. The impact of this conflict should not be underestimated. For if the true intention is to build communities that are attractive to younger elderly people, then the population characteristics would indicate that the effort has been a failure.

Even more serious is the implication that those who design the physical structures that house these facilities, and those who are responsible for the day-to-day operation of the facilities, are working at cross purposes.

The data collected in this study point to the fact that continuing care retirement communities are widely diverse in terms of size. There are small communities designed to accomodate as few as sixty-four individuals as well as large communities designed for as many as eight hundred and ninety-four people.

However, the provision of supportive services, and especially health related services, in even the smallest of these communities is a very complex task requiring much effort. As the size and the diversity of needs of the resident population increases, there is a concomitant increase in the complexity of the task. It is to their credit that those responsible for the day-to-day operation of these communities manage, in large part, to accomplish this task with few serious problems.

CHAPTER EIGHT
THE STRUCTURAL CHARACTERISTICS OF FLORIDA'S
CONTINUING CARE RETIREMENT COMMUNITIES

Structure, as a concept defining continuing care retirement communities, may have at least three related but separate meanings. Gerontologists, especially those who are not also sociologists, tend to use the word to refer to the actual physical buildings that make up a retirement community. Sociologists, and gerontologists who are also trained in sociology, tend to reserve the term for situations when they are attempting to describe the arrangement of social variables that are germane to a specific group of people--in this case, elderly residents of retirement communities. To further complicate the situation, those engaged in organizational research, usually irrespective of their primary discipline, tend to have yet another use of the word that is related to the organization itself as a social system, but that is primarily intended to describe the relative organizational power attached to various internal positions in a particular organization.

Although the traditional sociological concept of structure as an arrangement of social variables and their impact on various social groups is unquestionably an

important one for the understanding of any living arrangement, and indeed the populations of these continuing care retirement communities were discussed briefly in Chapter Seven, that is not our primary concern here. Similarly, the actual physical structures involved were discussed extensively in Chapter Six. Here, however, we are concerned with the organizational sense of the word structure.

It is recognized that the interrelationships among the three senses of the word structure mentioned here are complex indeed. One cannot separate the structure of an organization from the structure of the society that produces and maintains it. And the physical structure, that is the buildings, may also have an impact on organization structure as well. For our purposes however, a rather narrow and organizational sense of the word structure will be employed in order to more fully understand the continuing care retirement community.

Organizational Structure

Miles (1980) has defined organizational structure as Those features of the organization that serve to control or distinguish its parts. Structure is generally expressed in terms of the division and specialization of work and the methods of coordination and control. (p.18)

Similarly, Hall (1982), relying on the work of Blau (1974) and Ranson, Hinings, and Greenwood (1980), conceptualizes organizational structure as essentially a

coordination and control device serving three basic functions.

First and foremost, structures are intended to produce organizational outputs and to achieve organizational goals. Second, structures are designed to minimize or at least regulate the influence of individual variations on the organization. Structures are imposed to ensure that individuals conform to requirements of organizations and not vice versa. Third, structures are the settings in which power is exercised, in which decisions are made, and in which organization's activities are carried out. (p.54)

The generally accepted view of organizational structure as a coordination and control device has been discussed by Blau (1974), Hall (1982), Aldrich (1979), Meyer and Rowan (1977), Meyer, Scott, and Deal (1981), and others. A similar view, held by Thompson (1967, p.51) perceives structure as a "patterning of relationships."

The common implication of these definitions is that coordination and control are seen as the essential elements in a system of relationships that is, even if it is not wholly rational, at least goal directed to the extent that it exists for a purpose. Thus, as it applies to continuing care retirement communities, structure refers to the established mechanisms of coordination and control that are specifically oriented toward providing services to a population of older people.

As alluded to in Chapter Three, Zey-Ferrell (1979, p. 139) has identified four structural components of organizations that have relevance to continuing care retirement communities. In very broad terms complexity,

formalization, centralization, and communication are presented as the determining factors in coordination and control.

Complexity: General Horizontal Differentiation

As discussed in Chapter Three, there are two main types of horizontal differentiation that are important to understanding the complexity of continuing care retirement communities. The first, referred to here as general lateral dispersion, involves the number of services provided to the residents as well as the number of separate organizational goals that the community attempts to achieve.

Support Services

Quite beyond the obvious category of housing services that are provided by all of Florida's continuing care retirement communities, the lifestyle provides other services as well. These may be divided into the categories of health related services, services related to the social functioning of the residents, and services aimed at enhancing an individual's performance of what gerontologists call activities of daily living. Another important although less frequent category can be described as religious support services.

Beyond the nursing services that are available in about eighty-five percent (35) of the licensed continuing care retirement communities studied, some communities

offer other health related services to residents outside the nursing home setting. Seventy-two percent (30) of the communities in this study offer their residents what can broadly be called non-institutional health related services. There is, however, wide variation in both the intensity and extent of these services.

In some communities the extent of these health related services amounts to little more than an emergency referral station that is staffed on a part-time basis by resident volunteers. Generally, these facilities offer only referral and emergency contact services. In addition, such communities might offer free, or reduced fare, transportation to facilities outside the community offering health related services. Other communities offer full clinical treatment delivered by a professional staff which usually includes one or more full-time licensed nurses and a part-time physician.

Obviously, health related services in the typical community are between these extremes, but there is a clear tendency for communities to rely on services that are available outside the community and only offer those that are not easily obtained in the larger community. Thus, communities that are physically isolated in rural areas might be expected to have more extensive non-institutional health services than those that are located in less isolated areas. Based upon the data supplied by the respondents in this study, that would indeed seem to be the case.

Another very important group of services that are offered by these communities involves planned social activities. Correctly or not, it is widely believed that activities designed to promote social contact among residents in non-traditional living arrangements, especially contacts involving persons from outside the particular facility, help to enhance and prolong the well-being of the resident population. Because of this, it is not surprising to find that about eighty-five percent (35) of the communities in this study have a planned program of social activities for their residents and, that these communities list social activities as the among the most important services they offer.

As interesting as these communities are, perhaps more interesting are the communities making up the fifteen percent (6) that offer no such social services. Although it is beyond the scope of this study to construct a profile of these communities, it is reasonable to speculate that, if all other reasons for not offering social services are removed--such as reasons related to the operators and to the location of the facility--those facilities that find it unnecessary to provide planned social services do so because the residents are either too self-isolated or too frail to participate in them.

Again, there is wide variation in both the intensity, a qualitative component, and the extent, a quantitative component, of the social programs offered by continuing

care retirement communities. In some communities, social programs consist of little more than an occasional program provided by some organization in the surrounding community on an irregular and somewhat informal basis.

In contrast, some of these communities have full-time social programming departments that arrange a variety of social opportunities and publish schedules far in advance of the actual event. As an extreme example, in one of these communities located in a particularly affluent area of South Florida, there are three separate schedules of concurrent daily events that residents can choose from and there is a weekly entertainment event featuring paid entertainers.

As with health related services, the typical community offers social services that are somewhat less ambitious than the example above. However, it is still instructive that eighty-five percent of the communities in this study offer at least some level of planned social activities to their residents.

One group of services that are especially important to the more frail elderly residents are services related to what gerontologists call "activities of daily living" (ADL). These services are designed to meet daily needs of residents in an attempt to prolong their independence. Often called "home help" or "assisted living," these services include such widely diverse efforts as cooking, personal hygiene, financial management, management of

medication, and transportation. In fact, except for the nursing services that are characteristic of the majority of continuing care retirement communities, these ADL assistance services are a primary definitional difference between what is generally thought of as a retirement community and the special case of the continuing care retirement community.

Thus, it is not surprising to find that about sixty-six percent (27) of the communities in this study offer formally organized assistance services to their residents as an integral part of community life. These formally established programs range from comprehensive and flexible programs offering a wide variety of services, much like that found at Pine View Village, to less flexible and somewhat more modest programs offering limited assistance to residents on the basis of a specific set of need categories established by the community itself.

One of the interesting facts of ADL type support services is that, in many non-traditional living arrangements, the informal network of service delivery by both staff and residents is profoundly important to the continued well-being of the more frail residents (see, for example, Streib, Folts, and Hilker, 1984). These informal networks seem to operate regardless of whether the community itself has a formal structure for the delivery of such services and is probably a positive indication of a healthy social relationship among the residents rather

than a sign of the failure of the facilities to meet the resident's needs.

Finally, what we have called "religious support services" are provided by about seventeen percent (7) of the communities in this study. These services range from actual religious instruction in a particular denomination, to the provision of facilities where like-minded residents can practice their religious beliefs and rituals.

Of interest here is the fact that, although only seventeen percent (6) of the communities provide religious support services, about fifty percent (21) of them are affiliated with one or another of the organized religious denominations. What this implies is that although there are facilities which give preference to members of certain denominations and which actively include religious beliefs in the day-to-day operation of the community, the majority of the communities, even the ones sponsored by a particular denomination, do not. In practice, few communities actually discriminate against potential residents because of their religious affiliation or lack of it. However, it is clear that religious activities are an important component in at least some continuing care retirement communities.

Organizational Goals

Another indicator of general lateral dispersion is the number of formally established goals present in an organization. The linkage between the complexity of an

organization and the number of goals present is in the fact that as an organization attempts to meet more and more goals, it is likely to establish additional structures to specialize in the pursuit of these newly established goals.

There is, however, a certain difficulty in attempting to make a determination of the goals of a continuing care retirement community. The difficulty is that the organizations that establish these living arrangements tend to adhere to very broad, non-specific, and inclusive goals that do not lend themselves to precise definition. It is not uncommon to find the formal goals of a continuing care retirement community formally stated as "the provision of a safe, supportive, and healthy living environment for elderly persons."

In the sense that a supportive environment and continuing care both suggest a flexible array of services to meet changing needs, the formally stated goals of these organizations tend to be similarly flexible to include a wide variety of possible activities. Because of this, performance criteria are ill defined and it is difficult to judge the standards of operation of these communities. Put another way, from the perspective of the organization, it is difficult judge just when the community is doing a "good job."

The situation is made less complicated by the fact that each of the types of services discussed above carries

with it a set of important organizational goals, even if they are only implied "sub-goals." Thus, the actual performance standards of the service delivery system become the organizational goals to which continuing care retirement communities aspire and the criteria by which they are judged. Thus, the provision of a safe, supportive, and healthy living environment, the formally stated organizational goal, is judged by how well the community meets the performance standards it has set for its various departments.

Specific Horizontal Differentiation

The remaining important form of horizontal differentiation in an organization is specific lateral dispersion. As with general lateral dispersion, discussed above, specific lateral dispersion has two primary elements. First, the number of departments in an organization directly suggests its complexity. Similarly, but less directly, the number of subdivisions within the different departments is an indicator of the complexity of those subdivisions.

In the present study, organizational charts from about seventy-one percent (29) of the responding communities were returned with the questionnaires. Those failing to respond to that particular question were contacted and the result was that information on the number of departments was obtained from all but one (40) of the communities.

The number of separate departments within continuing care retirement communities in this study ranged from three to eleven with a modal category of five. Within these departments the number of subdivisions ranged from zero to five with two as the modal category. A cross tabulation of the number of departments by the actual size of the resident populations and the number of levels in the organizations is located in Appendix B. The data suggest that there might be a relationship between the size of the resident population and the complexity of the organization.

Thus, communities with large populations might have more departments and more subdivisions within those departments than communities with small resident populations. Put another way, the size of the resident population might have an impact on the complexity of the supporting organization in that larger communities have more departmental divisions. Statistical confirmation of this general trend must await the collection of more data, although the trend is clearly apparent in the raw data presented in Table 19.

Complexity: Vertical Differentiation

Although lateral dispersion is a good indicator of the complexity of an organization it is, by itself, incomplete. Another important element of the full picture is vertical differentiation or, as it shall be referred to here, hierarchical dispersion. Just as lateral dispersion is, in its most basic form, a simple count of the number

Table 19 The Size and Departmental Divisions of Florida's Continuing Care Retirement Communities

	Capacity	Number of Departmental Divisions
<hr/>		
Community:		
1	498	10
2	311	8
3	124	5
4	217	5
5	260	7
6	64	5
7	100	5
8	440	11
9	630	9
10	437	3
11	156	6
12	160	4
13	240	5
14	460	6
15	827	8
16	450	6
17	523	6
18	770	8
19	739	8
20	522	5
21	894	5
22	212	5
23	325	5
24	96	6
25	381	6
26	402	6
27	346	--
28	380	8
29	452	7
30	293	8
31	370	5
32	199	5
33	170	8
34	75	4
35	375	8
36	700	6
37	478	3
38	418	9
39	370	5
40	199	5
41	377	6
Mean	376.6	6.25
s	205.4	1.80

departments and subdivisions along a horizontal plane, hierarchical dispersion is, in its most basic form, a count of the number of levels in an organization along a vertical plane.

The continuing care retirement communities in this study have a hierarchical dispersion that ranges from three levels to thirteen levels, with a modal category of five levels. Again, a simple cross tabulation, located in Appendix B, suggests that there is a weaker association between the number of levels and the size of the resident populations in CCRCs. This suggests that, unlike the case of lateral dispersion, large communities and small ones may be similar in their complexity.

Weaker still is the association between the number of departments within continuing care retirement communities and the number of levels within those organizations. Put another way, the data would seem to suggest that the number of services provided to the residents of these communities is related to the size of the population, but that the hierarchical arrangement of the organizational structure is not. Table 20 presents the raw data comparing the number of hierarchical levels to the number of departments within these communities.

Figure 5 presents a typical organizational chart for continuing care retirement communities located in Florida. It is based on a composite of the thirty organizational charts received from the respondents, and it reflects the modal categories for both lateral and hierarchical dispersion.

Table 20 The Number of Levels and Departments In
Florida's Continuing Care Retirement
Communities

	Capacity	Departmental Divisions	Hierarchical Levels
Community:			
1	498	10	5
2	311	8	4
3	124	5	5
4	217	5	8
5	260	7	5
6	64	5	3
7	100	5	5
8	440	11	6
9	630	9	9
10	437	3	9
11	156	6	10
12	160	4	5
13	240	5	8
14	460	6	13
15	827	8	7
16	450	6	5
17	523	6	5
18	770	8	8
19	739	8	5
20	522	5	5
21	894	5	5
22	212	5	5
23	325	5	10
24	96	6	5
25	381	6	7
26	402	6	7
27	346	--	--
28	380	8	8
29	452	7	10
30	293	8	10
31	370	5	7
32	199	5	4
33	170	8	5
34	75	4	3
35	375	8	6
36	700	6	5
37	478	3	7
38	418	9	10
39	370	5	8
40	199	5	4
41	377	6	7
Mean	376.6	6.25	6.58
s	205.4	1.80	2.26

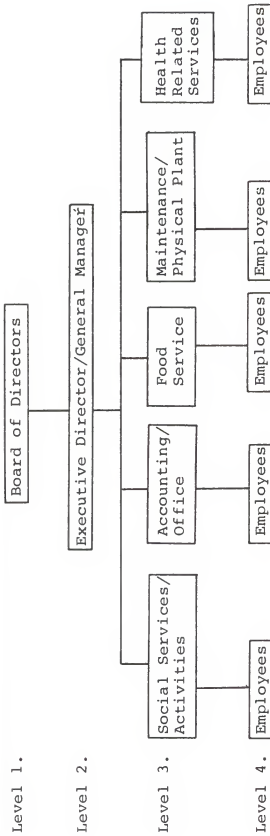


Figure 5 Typical Organizational Chart for Florida's Continuing Care Retirement Communities

One of the problems associated with the use of hierarchical levels as an indicator of organizational complexity is that within many organizations there is wide variation in the number of subdivisions within the departments. For example, Figure 6 presents the hierarchical dispersion for two departments in the same retirement community. Notice that the Housekeeping Department has but two levels while the Food Service Department has four separate levels.

The problem, which has been noted by Hall (1982, p.76) is basically this: which department gives the more complete summary statement of the true hierarchical dispersion of this community.

The approach to this problem is not so much a solution as it is a recognition of it as a problem and the adoption of a convention for counting the number of levels in an organization. That convention, first suggested by Hall, Haas, and Johnson (1967, p.906), and later refined by Pugh, Hickson, Hinings, and Turner (1968, p.78), is that the number of hierarchical levels of a community is determined by the number of levels of the department with the largest number of subdivisions. Or, put another way, the number of levels is taken to be the number of formally established positions in the longest single (vertical) division.

This is not to suggest that mathematical manipulation has no use in producing a summary statement of the

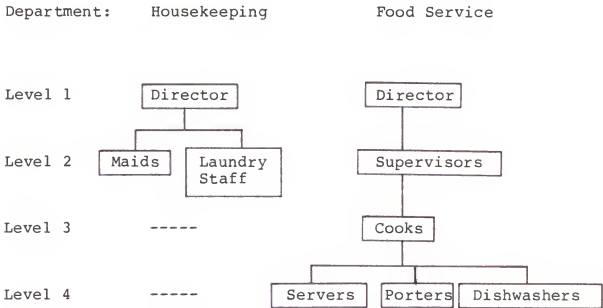


Figure 6. Hierarchical Dispersion of Two Departments Within
The Same Continuing Care Retirement Community

hierarchical dispersion of a particular class of organization. Quite the contrary, Hall, Haas, and Johnson (1967, p.906-907) themselves employ the "mean number of levels," that is the total number of levels of all departments divided by the number of departments, of an organization as a descriptive statement when comparing organization types.

Here, however, since this study is an attempt to lay the groundwork for further exploration into these communities, it seems more important to demonstrate the complexity of a more or less typical community than to calculate a summary statement. Hence, the convention of counting the number of levels in the vertically "deepest" division is used in the development of the typical organizational chart presented in Figure 5.

Complexity: Spatial Dispersion

A final indicator of complexity is the spatial dispersion of a particular organization. Spatial dispersion, in the special case of continuing care retirement communities, is related to the affiliation of a particular community with a parent organization or sponsor. Implied by spatial dispersion is the idea that decisions may be made at a location more or less removed from the actual location of the focal organization. This has an important implication for organizations delivering services to elderly people especially if spatial dispersion also means that those making the decisions are removed from the day-to-day operation of the facility.

As discussed above, about half (20) of the communities in this study are affiliated with a religious organization and another forty-one percent (17) report no affiliation. In addition, only about seventeen percent (7) report that they are profit-making organizations. Given the rather benign nature of religious affiliation (see for example Streib, Folts, and Hilker, 1984), and the fact that only about eight percent (3) of the remainder of these communities report any affiliation at all, it might be reasonable to conclude that decisions about the day-to-day operation of continuing care retirement communities is concentrated "on site," so to speak.

However, among the communities responding to this study, about thirty-four percent (14) of them report that their decision making is influenced by outside organizations other than the normal regulatory agencies. In addition, about forty percent (16) of them report that their operation is monitored by one or more outside organizations other than regulatory agencies. Thus, it would appear that there is at least a substantively significant amount of spatial dispersion among these retirement communities as it refers to decision-making.

Formalization

Formalization is another structural variable that is important to understanding continuing care retirement communities. As discussed previously, formalization involves the idea of written procedures and relationships

between and among the elements of a community. The existence of formally defined positions, procedures, and relationships in no way negates the importance of the informal network that operates within an organization.

Quite the contrary, as suggested in housing studies by Streib, Folts, and Hilker (1984), Hilker (1983), and in the work of Thompson (1967), in organizations with oppressively formalized procedures, the informal network may be more important than the formal ones.

Although our survey data do not examine the issue of informal coordination and control mechanisms, the interview data suggest that not only do the two operate side by side, but they also suggest that wherever a formalized mechanism does not exist it can be reasonably assumed that it is because the informal mechanisms provide sufficient, and indeed in some cases more efficient, control for the day-to-day operation of the community.

There are several different categories of phenomena that are relevant to a discussion of formalization in continuing care retirement communities. These are roles, authority relations, lines of communication, and norms and sanctions.

Roles and Authority Relations

Inasmuch as roles are related to job descriptions, and the interview data suggest that roles within these organizations are in fact derived from formal job descriptions, it would seem that continuing care

retirement communities rely almost exclusively on formal role designations. All of the communities contacted had written and formalized job descriptions, and about eighty-five percent (35) of them had formal and specific definitions of the tasks that the person occupying each position was to perform. Additionally, about eighty percent (33) reported that they had formalized descriptions for each position concerning that position's responsibilities with regard to the overall organization.

In addition to the written job descriptions, almost all of the communities had formalized what amounts to an organizational chart specifying not only the relative authority positions within the community, but the lines of communication as well. In fact, about ninety percent (37) of the respondents had a prepared organizational chart that was distributed to all employees. And although all but one of the remaining communities had no formal organizational chart, even they did have what can be described as an "organizational narrative" containing similar information.

The one community that had neither the organizational chart nor the organizational narrative, reported that it was in the process of reorganizing its structure and that as soon as that process was complete, a formal organizational chart would in fact be constructed.

Lines of Communication

Although the organizational charts suggest both lines of authority and lines of communication, some communities rely more on informal communication than do others. For example, in one community with a particularly charismatic chief executive, there are clearly established lines of communication from the employees occupying the lowest levels of the hierarchy to the highest level of the hierarchy. However, partly due to the personality of the chief executive, the informal lines of communications are often more important than the ones implied by the organizational chart. In this community it is not uncommon to find problems dealt with at a personal and somewhat less well documented level.

To the outside observer, especially one who relies exclusively on historical records, this community would appear to be without serious internal problems. In fact, in this particular case, it was only after careful and somewhat delicate discussions with key informants that it was determined that this community was similar to others in that it had many of the same problems in its day-to-day operation.

In contrast, in another community, ostensibly at least, all communications affecting the operation of the facility were expected to be in written form. To the outside observer, this community would appear to be rife with internal problems when in fact, the appearance was

due primarily to an attempt to document all disputes and all incidents however trivial.

Another important area involving formalization is the area of norms of performance and sanctions for less than satisfactory performance. All of the communities in this study had formal job descriptions that, more or less, clearly defined performance standards for each job. In addition, some communities performed periodic evaluations of each employee. Commonly, however, communities rely on supervisory staff, usually department heads, to determine if an employee is performing his or her job in a satisfactory manner.

.. About eighty-eight percent (36) of the communities in this study had written dismissal procedures. These generally require that the chief officers of the organization at least be informed of the situation before any dismissal action is taken. In at least one case, employees are granted a formal hearing before a grievance committee before they are dismissed. The other twelve percent (5) of these communities apparently rely on the summary judgment of the supervisory staff.

Centralization

The idea that power, or decision-making authority, is concentrated at the top of the hierarchy of organizations is one component of what organizational researchers call centralization. As noted in Figure 5, typical continuing care retirement communities have in common a board of

directors, an executive officer (usually referred to as the executive director or the general manager), and department heads appointed to supervise the operation of the various departments within the community. In fact, although some communities had considerably more, all of the communities in this study had at least three levels of what, for lack of a more descriptive term, we shall call top management.

In any continuing care retirement community the amount of money placed at risk is large, both in terms of initial investment and in terms of personal financial resources of the residents. And, since the final authority, responsibility, and liability for all decisions rests, both legally and in a regulatory sense, with the board of directors, it is reasonable to expect that the board would take an active and direct role in the day-to-day decisions that are made.

The data, however, suggest that the boards of directors of these facilities are not as involved as one would expect. While it is clear that decision-making authority in these communities is concentrated at the top of the hierarchical structure, it is the executive directors and the department heads who make the decisions.

In a modification of a method suggested by Pugh, Hickson, Hinings, and Turner (1968) intended to explore decision-making autonomy, the questionnaire used here listed fifteen decision-tasks for which respondents were

asked to indicate the lowest ranking member in the organization who would have the power to make the particular decision. Table 21 presents the fifteen decision tasks and a summary of the findings.

The decision-tasks were deliberately selected to make a distinction between the top authority positions in the organizations. Specifically, the intent was to be able to make at least some judgment as to the kinds of decisions in which boards of directors, executive officers, and department heads are involved.

Included in the fourteen tasks are decisions related to the day-to-day operation of these facilities, the coordination and control of the various departments within the facilities, and the overall direction or goals of the organization.

The data confirm the general expectation that operational decisions are made by supervisory staff, coordination and control decisions are made by the executive director, and goal oriented decisions are made by the boards of directors. Although the data confirm this general trend, there are some interesting anomalies that require further discussion.

Operational Decisions

The list presented in Table 21 contains three decision tasks that are operational in the sense that they are related to the day-to-day performance of the facility. These are: decisions related to the type and brands of

Table 21
Decision-Tasks.

Percent of Responses** Decision-Task	Board of Directors	General Manager	Dept. Heads
Operational Decision-Tasks:			
1. Select Type or Brand of Equipment to be Used.	7.3%	19.5%	73.2%
2. Methods of Work	0.0%	22.0%	78.0%
3. Work Allocation	0.0%	9.8%	90.2%
Coordination and Control Decision-Tasks:			
4. Establish Supervisory Positions	4.9%	80.5%	14.6%
5. Appoint Supervisory Staff	4.9%	73.1%	22.0%
6. Promote Supervisory Staff	0.0%	78.0%	22.0%
7. Set Salaries of Supervisors	4.9%	90.2%	4.9%
8. Dismiss Supervisory Staff	0.0%	73.2%	26.8%
9. Select Non-Supervisory Staff	0.0%	17.1%	82.9%
10. Assign Supervisor Responsibility	4.9%	70.7%	24.4%
Goal Related Decision-Tasks:			
11. Design or Implement Programs	12.2%	48.8%	39.0%
12. Set Fees	63.5%	36.5%	0.0%
13. Set Admission Standards*	61.0%	34.1%	0.0%
14. Allocate Funds	43.9%	43.9%	12.2%
15. Create New Facilities	85.4%	12.2%	2.4%

* One community has its admission standards set by regulatory agencies.

** n = 39

equipment to purchase, the methods of work to be employed, and the actual allocation of work. For all three tasks, the majority of the communities report that it is the department heads who make the decisions. However, in the case of purchasing equipment and determining the methods of work to be employed, about twenty percent (8) of the communities report that the executive director makes the decision. In no case did a community report that the board of directors was involved in making any of these decisions.

Coordination and Control Decisions

The questionnaire contained seven questions related to the coordination and control of these communities. As expected, the majority of communities report that for all seven of the decision-tasks it is the general manager or executive director who is involved.

However, of interest is the fact that the data suggest the executive directors are given broad powers with regard to the supervisory staff. Not only are these individuals empowered to select, promote, and even set the salaries of the supervisory staff, but in about eighty percent of the cases they can actually establish new supervisory positions.

In only one coordination and control decision-task are the department heads reported to be involved more often than the executive director and that is the instance of selecting non-supervisory staff. This implies that it

is the department heads who are responsible for the employment and dismissal of the employees who work closest to the residents in these communities.

Directional and Goal Decisions

The findings discussed above are generally consistent with what one would expect in any business organization, even non-profit business organizations. However, continuing care retirement communities are not merely business organizations. They offer as their product housing and a lifestyle that, in a very real sense and for all but the least expensive of the communities included here, is beyond the financial means of all but a very few elderly people. For the most part, entrance fees and monthly charges constitute what is probably the single largest expense of the elderly people who live in them.

Similarly, the physical structures alone represent an enormous investment by those who underwrite and ultimately pay for the construction of these facilities. Add to that the fact that the average number of employees at the facilities in this study is 135, and it is easy to see that retirement communities are indeed "big business" in any sense of the phrase.

Because of the financial investment required, and because even though these communities are businesses they are somewhat unique businesses, it is reasonable to expect that the persons ultimately responsible for the continued

operation of these facilities would be directly involved in the goal oriented decisions if not the operational ones.

The questionnaire contained five decision-tasks that are related to the goals and future directions of these facilities. In the case of three of them--setting fees, setting admissions standards, and establishing new facilities--the results were as expected. In all three cases a convincing majority of the communities reported that the boards of directors made those decisions.

However, it is interesting that in the case of setting fees and admissions standards, about thirty-five percent (14) of the communities reported that the executive directors were responsible for those decisions.

Incidentally, in one case, the community reported that it was the state regulatory agency that was responsible for setting the admissions standards. Further exploration uncovered the fact that this particular community was in receivership and the state regulatory agency indeed had taken control of the business operation of the community.

Perhaps the most unexpected finding was that the executive directors and department heads in about half of the communities have broad discretion in the creation of new programs and services. Forty-eight percent (20) of the communities reported that the design or implementation of new programs could be accomplished by the executive

directors and thirty-nine percent (16) reported that department heads had the power to make the decisions.

Summary

The word "structure" has many different uses. Gerontologists have used it to describe the physical buildings of a particular housing arrangement. To sociologists, the word has a social meaning and implies the variables that mark the relative positions of different groups in society. Finally, researchers who are interested in the organizational aspects of a particular set of phenomena have a third meaning for the word.

To this last group, structure means the features within any organization that act as control mechanisms to minimize variation. Although the three meanings are related, it is this third meaning which is important to the present study.

The term structure, as it is used here, consists of at least four very important components. Complexity, formalization, centralization, and communication are all related to the environmental requirements placed on the focal organization and all indicate something about how the organization operates.

The communities in this study were found to vary considerably in the number of departments they have. This is indicative of the diversity of services offered. However, the communities were strikingly similar with regard to the number of levels within their organizations.

This would tend to suggest that the operating environments of the communities, as a whole, are also similar.

The communities also tend to rely on formalized job descriptions, procedures, and methods of delivering the services to the residents. However, there are indications that the informal networks are also important.

The data suggest that the executive directors, or as they are called in some communities; the general managers, have extraordinary powers with regard to the day-to-day operation of these communities. In fact, the involvement of the boards of directors tends to be limited to issues related more to the goals and future directions of the communities than to their actual operational performance.

Again, although most of the communities reported that they had formalized pathways for intra-organizational communications, the informal networks proved to be another important aspect.

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CHAPTER NINE
ENVIRONMENTAL ELEMENTS OF FLORIDA'S
CONTINUING CARE RETIREMENT COMMUNITIES

As discussed in an earlier chapter, components of the environment were introduced only relatively recently into organizational research. Before, organizations were viewed as rational decision-making entities that always acted in the interest of achieving the formal goals of the organization in the most efficient way available. When the operating environment was considered at all, it was considered to be a constant. And, since it was, by definition, outside the organization, it received little attention.

Perhaps part of the reason for not considering the environment in early attempts at understanding complex organizations was the fact that the concept is, of necessity, a residual one containing everything that is not specifically within the organization itself. Put another way, after the boundaries of an organization are established, the environment is everything that remains.

The problem of residual categories, such as this, is that, in an absolute sense and if taken to the extreme, all elements of the category apply to all other elements of the category, at least at some level. In the case of

organizational research, the "environment" consists mostly of other organizations. Thus, the concept "environment," although easily defined as that which is not within the focal organization, is in fact highly complex and very difficult to manage.

Fortunately, there are conceptual foundations for sorting out the important aspects of the environment. Dill (1958) provided one such framework when he introduced the term "task environments." Evan (1968) introduced a similar concept he called "organization set" (meaning a set of organizations), but common to the two ideas is that only certain components of the environment are important to the focal organization at a particular time. By sorting out what is not important, the residual category "environment" presents a far less formidable aspect.

Task environments are defined by Thompson (1967, p.28) rather simply as "those organizations (elements) in the environment which make a difference to the organization in question." Dill (1958) had suggested that these task environments could be categorized as customers, suppliers, competitors, and regulatory groups.

All four of Dill's task environments are important to an analysis of continuing care retirement communities. With respect to regulators, competitors, and suppliers, the boundaries of these communities are fairly well defined and the relationships tend to be at a level that is reasonably simple to observe and understand. In the

case of the customers, however, the relationships and, more importantly, the boundaries tend to be less easily disentangled.

A common gerontological perspective would seem to treat the delivery of housing services, and indeed most services, as a unidimensional coordination effort centered around arranging a set of available components so that the needs of the potential residents are balanced against the ability of well meaning organizers to meet those needs. Usually, the entire enterprise is viewed from the perspective of the resident and success or failure is generally judged by how well the needs of the residents are met.

One of the advantages of the organizational perspective is that, while the end product is still considered, this perspective also directs attention toward the fact that these facilities are fundamentally in the business of converting resources--human, financial and material--into housing and other services for their elderly residents. The whole process is viewed not only as a coordinated effort aimed at meeting the needs of the residents, but as a complete process involving resident needs, organizational goals, and personal goals as well.

Given the rather stringent statutory requirements related to the financing and continuing funding of these communities, few communities must seek funds from outside. This is not to suggest that the financial condition of

these facilities is of no concern or that these communities, especially the non-profit ones, do not actively and aggressively seek whatever outside funding is available, but as a general rule, continuing care retirement communities in Florida are currently able to meet their financial obligations and few are in danger of the type of financial failure that characterized the case of, for example, Pacific Homes, Inc. (Williams, 1985).

Task Environments: Regulators

Given the nature of the services delivered by these communities, it should not be surprising to find that the regulatory mechanisms designed to insure standards of performance have a profound impact on their operation. From the time these communities are planned, even before they are actually built, regulatory agencies are involved. As mentioned in an earlier chapter, in Florida, a continuing care retirement community cannot even begin operation until at least fifty percent of the available places are reserved.

This situation is made more complex by the fact that different regulatory agencies are involved at different levels and a community must satisfy all the requirements of each agency. Now, from a practical standpoint there is great variation in the ability, and even the desire, of regulatory agencies to enforce their own standards. One need only read the frequent newspaper accounts of abuse and deceit to conclude that some regulatory agencies

cannot, or will not, enforce standards of operation that were designed to protect the consumers.

Regardless of the reality of the enforcement effort, from an organizational perspective at least, regulatory agencies have an extraordinary amount of influence on the establishment and successful continued operation of these communities.

There are three levels of regulatory agencies that impact the day-to-day operation of continuing care retirement communities. For the sake of simplicity, these can be categorized as; federal, state, and local regulators. Within these broad categories, regulatory contact is concentrated in a relatively small group of organizations.

At the federal level there are three main regulators. The Department of Housing and Urban Development (HUD) is involved only to the extent that federal money or loan guarantees are used in the construction and operation of the physical structures. There are several of these communities, Pine View Village for example, that offer rent subsidies and that have received loan guarantees for construction. In any event, the number of communities that are regulated by HUD is small.

Most communities are built with non-government financial resources. And, as a result, the impact of HUD is minimal. This is supported by the data from the survey in that only four (9.8%) of the communities reported that

in the past year HUD was the source of a problem serious enough to require a reply.

There is one other federal level regulatory agency that is particularly important to these communities. Medicare and the Social Security Administration, combined here as one agency, are involved in regulating the health care offered by these communities. In communities with acute care clinics or with organizational ties to acute care hospitals, the medicare regulations are more important.

Although the federal level regulators play an important, if only minor, role in the operation of continuing care retirement communities, state level agencies, of which there are three, represent the bulk of the regulatory effort. In Florida there are two primary state agencies which are responsible for the operation of these communities. Both the Department of Health and Rehabilitative Services (HRS) and the Department of Insurance (DOI) are involved. In addition, the state administered federal medicaid program has its own regulatory requirements.

Generally, HRS is involved with regulating the health care and supportive care components of these communities. The Department of Insurance is involved because the payment of an entrance fee by potential residents is construed as an insurance premium (see Netting and Unks, 1984; and Winklevoss and Powell, 1981). Together, these

two agencies are primarily responsible for regulating the operation of continuing care retirement communities in the State of Florida.

In addition to the state and federal regulation, these communities are also subject to, what we have called here, local regulation. Local regulation usually is limited to the county health departments, the business license bureaus, and the building and zoning commissions.

In all, a community utilizing federal grants or loan guarantees and offering an on site clinic, would be subject to eight different regulatory agencies any one of which having the ability to impose severe penalties for non-compliance. It is thus reasonable to conclude, and the data support this, that much organizational time and effort is spent monitoring and reacting to pronouncements by the various regulatory agencies.

Task Environments: Competitors

On its surface, this category of task environment would seem to include only other continuing care retirement communities. However, this is not the case. Not only do these communities have to deal with direct competition from similar communities, of which there are many, but they also must compete with other alternative living arrangements and with the more traditional living arrangements as well.

The continuing care retirement community is not the only supportive living arrangement available. Indeed, the

concept of alternative living arrangements, at least as it is understood now, implies some sort of support system that is unavailable "on the outside" (see Streib, Folts, and Hilker 1984; and Hilker, 1983). In fact, the development of stand-alone Adult Congregate Living Facilities (ACLFs), and the regulations that accompanied them, was the direct result of a desire for a non-institutional but supportive environment.

The primary attraction of these communities is that they offer continuing care. That, coupled with the fact that an attempt is made to attract relatively young and healthy elderly people, means that, in general, a more traditional living arrangement is also a competitor.

These communities are interested in attracting those people who need only minimal services at the present time, but who anticipate needing them, or who get satisfaction in knowing they are available, sometime in the future. This implies that the continuing care retirement community must compete with the possibility that the potential resident will remain in his or her present situation.

Another category of competitor involves the delivery of support services by family or friends. The admission of new residents to these communities is always a delicate balance between the desire of the community to attract relatively young and healthy elderly people, on the one hand, and the desire of the individual to obtain needed or anticipated support services on the other hand.

In this one sense then, the continuing care retirement community is in competition with the largely mythical "three generation family." If adequate support services can be delivered by family or friends, it is likely that an elderly person, who is otherwise inclined to do so, will delay moving into one of these communities until their present situation deteriorates to the point where the community is disinclined to admit them.

Task Environments: Suppliers

An important environmental component for continuing care retirement communities is that group of organizations referred to by Dill (1958) as "suppliers." The two most important suppliers are those responsible for medical resources and food resources. Important, although considerably less so, are organizations that supply materials and services related to the office operation and the maintenance of the physical facilities.

It is important to point out that the category "suppliers" is not intended in its narrow sense of "vendors," although vendors are included. Rather, it is intended in its broadest sense and includes all organizations and individuals, not a part of the focal organization, that are in any way responsible for the continuing operation of the community. This would include those organizations that supply medical materials, medical consultation, and any other medical resource. The distinguishing characteristic for this category is that

those supplying the resource, whatever it may be, are not a part of the focal organization.

Task Environments: Constituencies

There are many characteristics that make retirement communities unique as complex organizations. Perhaps the most important of these is what Dill (1958) referred to as "customers." However, a more descriptive term, and the one used here, is "constituencies." Put simply, the term constituencies refers to those for whom the organization is operated.

There are two main categories of constituencies in continuing care retirement communities. There are the residents, of course, and there are the employees. Each group differentially contributes to the overall functioning of the community and in turn each has needs that are met by the community.

One simple way of conceptualizing this is to think of the process as an exchange relationship between and among the various elements that make up these two groups. Residents exchange their financial resources and compliance for housing, food, and whatever other support services are provided. Employees, on the other hand, exchange their abilities and time for financial resources and whatever other benefits that accrue to employees of a particular community.

The residents of these communities constitute the single most important constituency of these organizations.

This group is also more complex than is readily apparent, because, often times, the families of those who choose this lifestyle are involved in the selection process as well as the day-to-day delivery of services to the residents.

The idea that elderly people are abandoned in retirement communities is simply not true. In fact, although this is admittedly not a qualitative assessment, fully fifty-eight percent (24) of the communities in this study reported that residents of their facilities had frequent visits by family and friends. And, all of the communities reported that the residents had visitors at least sometime.

Little attention has been given to the other constituency; the employees. As alluded to above this is probably because the main goals of a living arrangement for elderly people, at least as far as traditional gerontological research is concerned, are perceived to be directed almost exclusively toward the residents.

However, employees are a substantial and important group with which any organization must deal. This is demonstrated by the sheer numbers of people involved. In the communities responding to the survey, the number of employees ranged from twenty-seven to three hundred twenty with a mean of one hundred thirty-five ($s = 70.3$). This number reflects the actual number of people employed by the communities and no distinction is made between part-time and full-time employees. Further, where the number of

employees was reported as "full-time equivalents" (FTE), follow-up information was requested so that the actual number of people involved could be determined.

The data also suggest that turnover rates in continuing care retirement communities are such that an almost constant effort is required to ensure adequate staff levels. The mean number of employees who terminated their employment for all reasons in the year prior to the survey was reported to be 45.4 ($s=15.2$).

In addition, the case study data indicate that employees who leave their jobs tend to be concentrated in the lower levels of two important job areas directly related to the quality of resident care--food services and nursing services. In fact, it is not uncommon for nurses aides and food service employees, especially in the lowest levels of these positions, to leave their jobs with no prior notice. They simply fail to show up for work.

For whatever reasons employees decide to terminate their employment, that this is a problematic area can be emphasized by comparing the data for the number of employees and the number of terminations. The mean number of terminations (45.5) is about thirty-three percent of the mean number of employees (135).

The case study data collected by interview tend to support this assertion that about one-third of the employees of these communities must be replaced every year. The fact that many of these terminations are part-time employees does little to lessen the organizational

impact of replacing one-third of the work force each and every year.

Task Environments: Residual

There is another important element of the operating environments of these communities that is more abstract than the others. For lack of a better term, this category will be referred to as the residual task environment. Included here are elements located outside the focal organization but that are a part of the surrounding community. Essentially, anything else that is not a part of the focal organization and not a part of the four task environments identified above, would be in this category.

Fortunately, although still abstract, there are practical limits on what is included here. Specifically, the norms and standards of the surrounding communities must be assessed by the focal organization and these must be considered when decisions are made. Obviously, this is especially important when the social or economic impact of the retirement community is substantial.

Thus, included in this category are the standards of the surrounding community as well as organizations that are related to every day life in the surrounding community. Although the data do not specifically address this issue, it is reasonable to conclude that the importance of this category increases for retirement communities located in rural areas.

Environmental Linkages

One way to understand the importance and complexity of the task environments of continuing care retirement communities is to employ the conceptual device first presented by Emery and Trist (1963) and later refined by Adams (1975). This device, discussed in Chapter Two and graphically displayed in Figure 1, focuses attention on the linkages between the environmental elements and the organizations under scrutiny.

One of the problems with this device is that it implies both a single organization as the focal point to which the environmental elements are related and single organizations as elements of the environment. Here, we are clearly dealing with a category of organization that is made up of diverse members. Similarly, we are also dealing with categories of environmental elements.

However, it is interesting to note that, irrespective of the diversity found in such elements as size, location, financial arrangements, and sponsorship, the continuing care retirement communities responding to the survey face extraordinarily similar task environments. Whatever differences exist in the communities, it would seem that they are concentrated, not in the character or complexity of the task environments in which they attempt to operate, but rather, in the actual array of services that they offer. In addition, it would seem that these services are

similar and the only important differences appear to be in the intensity of service rather than in the extent of service.

The data suggest that there is one important exception to this. That is in the area of federal regulation. In some of the communities the Department of Housing and Urban Development (HUD) is an important element in the regulatory environment and in some it is not. Specifically, in about seventy percent (29) of the communities responding to the survey, HUD was not a part of their task environments. Incidentally, only two communities reported that they had even had contact with HUD in the year prior to the survey.

In any event, with the exception of this one category, the task environments of these communities are similar and in the discussion that follows, the focal organization will be a composite of the retirement communities responding to the survey.

Complexity of the Environment

Figure 7 is a graphic presentation of the types of linkages that exist between continuing care retirement communities and their task environments. Also included are the interorganizational linkages of a typical community as discussed in Chapter Eight.

Generally, within the communities the linkages among the various departments are quite simple. Employees report to department heads who report to a central director who

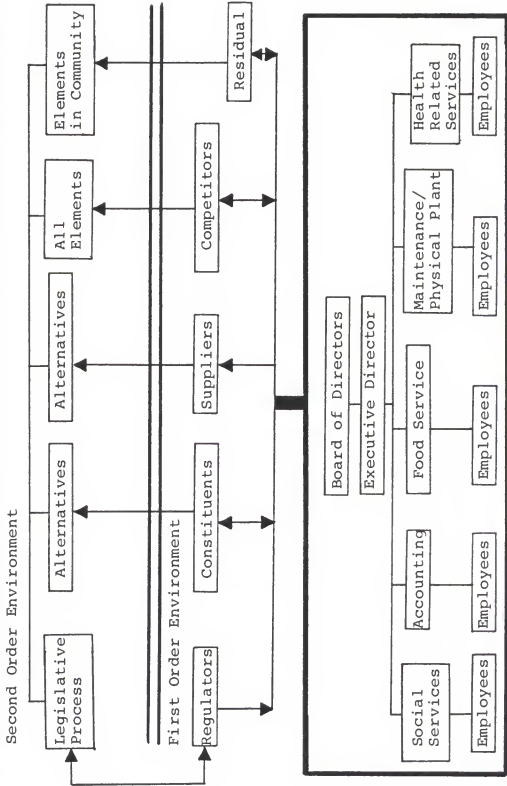


Figure 7 Environmental Linkages of Continuing Care Retirement Communities

is ultimately responsible to the board of directors. Although the departments themselves have a relationship with each other, the general pattern is for that relationship to be mediated by the director.

Outside of the focal organization, however, the situation becomes highly complex. Even in the first-order environment the relationships are complicated, but at the second-order, and higher, the relationships are extremely complex and must be presented here in summary form. An indication of the complexity of the higher-order environments is that for each of the competitors, in the first order environment of the focal organization, an exact duplicate of the entire figure exists. In any event, here we include the detail of only those elements in the first-order environment.

The relationship between the focal organization and the regulatory agencies tends to be one-way in that most of the contacts between the two are initiated by the regulators. From the perspective of the community, the regulators are clearly in a position of superiority in almost all of the interactions between the two. In fact, because of the power differential implied by the regulatory process, these communities exert an extraordinary amount of organizational effort in an attempt to first monitor the relationship (a predictive effort) and then comply with outcomes of that relationship (a reactive effort). The importance of this effort is obvious.

As the Figure 7 indicates, constituents present an interesting element of the task environment. Here, in the case of both residents and employees, the relationship tends to be two-way. As was discussed previously, both groups have what is essentially an exchange relationship with the focal organization. Logically, neither the constituents nor the organization could exist without the other. That brings up the issue of just what is the organization.

Ultimately, continuing care retirement communities are collections of both residents and employees. If either group is absent, the conceptual construct of the organization vanishes. Although one could logically have an organization without any residents one could not imagine that situation in any meaningful or practical sense. Thus, the relationship between the organization and the task environment labeled "constituents" is, in reality, a relationship among the constituents that make up the organization.

One way to simplify the problem is to take a relativistic view of just what "organization" means. Put simply, the organization, that is the community, is made up of employees when viewed from the perspective of the residents. Similarly, the organization is made up of residents when viewed from the perspective of the employees. Either way, this clearly points to the fact that continuing care retirement communities are indeed

special cases of organizations and should be treated as such.

Like the relationship between the regulators and the focal organization, the relationship with the suppliers tends to be one-way. Here, however, the "direction" of the relationship is reversed.

Because these communities represent a substantial resource to suppliers and because competition among the suppliers tends to be great, the communities occupy a position of superior power with regard to the individual suppliers. Thus, the relationship tends to be at the initiation of the community and clearly whatever impact the suppliers have on the community is minimal. This is not to suggest that suppliers do not cause problems for the communities, only that, because easily obtained alternatives exist and the risk is minimal, the communities do not exert much effort attempting to predict problems in advance.

Competitors represent an interesting element of the task environments of these continuing care retirement communities. Strict regulation, especially in the construction of new nursing homes and the requirement of a fifty percent reservation rate before operation can begin, has had the effect of limiting competition among these communities. In fact, the data suggest that whatever competition that exists, it is usually between similar facilities in the same general area. A better term would

be cooperation rather than competition to describe the relationship between these communities. For that reason, the linkage between the focal organization and the "competitor" task environment is denoted by a two-way line.

Finally, the task environment labeled "residual" represents the relationship between the focal community and those elements of the surrounding community that are important. This category represents, in one sense, background relationships since it contains all of those contacts that do not fit in any of the other categories.

Contained in the residual category would be such organizations as local church groups, civic organizations, educational institutions, and any other group that might have contact, deliberate or otherwise, with the focal community. It is also not necessary that groups in this category be formally organized and some elements of this category are not groups of individuals at all. Thus, such amorphous but influential phenomena as the general cultural background of the surrounding community, the norms and standards of that community, the financial and social impact of the continuing care retirement community on the surrounding community and even elements of the physical environment are included.

The financial and social impact are more important than they appear. In rural areas, the impact of a retirement community on the surrounding community can be

profound. In more than one case, a retirement community located in a rural area is among the largest employers in that area. In addition, the spending patterns of the communities usually represents a substantial portion of the economy in these areas and many local businesses could not survive were it not for the retirement communities.

The social impact of the retirement communities on their surrounding communities is also important. As mentioned before, continuing care retirement communities are, in a general sense, not for the poor elderly. Given the costs of residence in all but the least expensive of these communities, it is reasonable to conclude that the resident populations are generally more affluent than the general population of elderly people.

In some cases, and especially in the case of very rural areas, the resident's economic backgrounds may be fundamentally different from the backgrounds of those who live in the surrounding community. The impact of one retirement community on its surrounding community has been studied by Haas (1980). He concluded that

The overall impact of the retirement development on the surrounding community is positive. (it) has altered the social system, and some problems have occurred. (p.195-196)

Although it is easy to imagine how a particular surrounding community would benefit from the location of a retirement community in its immediate area, less obvious is the impact of decisions made by the retirement community organization.

For example, it is generally accepted that large concentrations of elderly people attract businesses providing services that would otherwise be either unavailable or available at greatly reduced levels. One group of services that is particularly beneficial to an area is health related services.

As long as the surrounding community can provide the service at a level and cost that is satisfactory to the retirement community, then both the retirement community and the surrounding community benefit by the arrangement. However, if the retirement community decides to provide the service internally, so to speak, then the surrounding community may be left without the particular service. Thus, the impact of organizational decisions made about what are essentially internal matters, can have a profound impact on the surrounding community.

This is not to suggest that the surrounding communities do not have an impact on the retirement communities as well, quite the contrary is the case. However, this example is presented to demonstrate the potential impact of decisions made by one element of a complex relationship.

Environmental Uncertainty

In Chapter Two it was suggested that there are three important concepts related to the operating environments of continuing care retirement communities. Complexity, uncertainty, and dependence, although related, were

presented as three elements of a framework from which to better understand the environments of these communities. As was discussed above, there appears to be little variation in the complexity of these environments since all of the communities must deal with the five basic elements presented in Figure 7.

Indeed, it would probably be difficult to find a group of organizations producing the same product or providing the same services that were not subject to the same basic level of environmental complexity. Whatever variation that exists is likely to be a response to local differences in the surrounding communities. Thus, the concept, while valuable here, is probably more useful in comparisons of dissimilar organizations. Still, a composite picture, like that presented in Figure 7, is important in understanding just how elements of the environment are related to the focal organization and to each other.

Before any discussion of environmental uncertainty can proceed, there are two issues that must be addressed. First, It is important to clearly define the meaning of the word uncertainty. Second, it is also important to make a distinction between uncertainty in the environment and uncertainty generated within the organization itself.

Uncertainty has many components, not all of them measurable and not all of them of equal importance to the focal organization. That is why those who study

organizations have attempted to construct broad categories that describe the overall stability, or lack of it, of the operating environments. Thus, terms such as "disconnected" (Emery and Trist, 1965), "turbulent" (Terreberry, 1968 and Aldrich, 1972), "shifting" (Thompson, 1967 and Dill, 1958), "variable" (Child, 1972), "volatile" (Burns and Stalker, 1961), "diverse" (Lawrence and Lorsch, 1969), and finally, "unpredictable" (Hinings, Hickson, Pennings, and Schnek, 1974), have all been proposed as part of a classificatory scheme to describe the operating environments of complex organizations.

In the present case, as is true with other types of organizations as well, the potential for causing uncertainty, itself a source of uncertainty, is related to the importance placed on the particular environmental element by the focal organization. Put another way, the risks involved in making an incorrect prediction are different for different elements in the environment.

For example, because the risk of incorrectly predicting the price of a particular supply is considerably less important to the overall survival of the organization, one would reasonably expect fewer resources expended related to this issue than with, say, the issue of what new regulations the Department of Health and Rehabilitative Services will institute.

The interview data collected in this study suggest that the issue of environmental uncertainty, as it applies

to continuing care retirement communities, is related to "problems," in its broadest sense, between the community and the five environmental elements discussed above.

Specifically, the concept of uncertainty has three primary components. First, whether or not a particular environmental element has in fact been the source of a problem of sufficient magnitude to require a response by the community; second, an assessment of the frequency of problems with organizational elements of the environment; and finally, an assessment of the quality of communication between the focal organization and the environment.

That all three of these indicators are, by implication at least, oriented toward "problems" is indicative of the underlying assumption that the concept of uncertainty itself is oriented toward "problems." For uncertainty to be an issue in these communities two things must be true. The risk produced by uncertainty must have empirical consequences that are serious enough to require organizational attention. Secondly, there must be the perception, on the part of the officials of the organizations, that there is value in predicting or at least anticipating the consequences of the actions of environmental elements.

Conceptually, If either of these is missing, that is, if the actions of organizations in the environment have little substantive impact on the focal community or if the actions defy prediction, then uncertainty will cease to be

an important issue in the sense that the communities will become passively reactive. Fortunately, the real world is not compelled to structure itself around conceptual possibilities and it is not very likely that communities will not at least make an attempt to predict environmental events, even if they are not very successful.

In fact, the in-depth interview data suggest that not only is uncertainty a primary concern among the officials responsible for the day-to-day operation of these communities, but much of their effort is directed at anticipating changes originating in the environment, and then formulating alternative plans as a reaction to those changes. Thus, rather than being passively reactive, the continuing care retirement communities in Florida can best be described as aggressively proactive in their contacts with elements of the environment.

It is also important to point out that by no means are all the problems related to uncertainty that face these retirement communities generated in the environment. Indeed, from the perspectives of the various department heads, and employees in the lower levels of the hierarchy, true environmental uncertainty and intraorganizationally generated uncertainty are, more or less, identical.

For example, those who actually deliver services to the elderly residents of these communities perform their duties in a manner prescribed by the officials of the organization and they probably have no idea, nor would it

matter, whether the performance standards by which they are judged are formulated by the organization or are set by the various regulatory agencies.

In any event, it is important to remember that the problems associated with uncertainty can be generated within the organization. Among the communities that responded to the survey, only about ten percent (4) reported that they had encountered serious problems generated from within their own organizations. Looked at from the other perspective, about ninety percent (37) of the communities reported no such self-generated problems. That implies that, for ninety percent of these communities, problems are seen as essentially an environmental issue. And that, in turn, directs attention to the importance of environmental analyses of retirement communities.

The data collected in the survey portion of this study focused on five potential sources of uncertainty. In terms of Figure 7, the five areas are contained in the environmental elements labeled "regulators," "suppliers," and "constituents." Specifically absent are the categories labeled "residual" and "competitors." In addition, the "constituents" category has been further reduced such that only employee unions and residents associations are included. The reasons for this are simple.

First, as a result of the in-depth interviews, the categories listed here were identified as the most likely problem sources and the organizations to which most of the

predictive effort is directed. In addition, however interesting the remaining categories appear, neither the residents nor the lower level employees could be interviewed in any systematic way given the limitations of time and resources available. Similarly, the whole issue of the impact of competitors on the focal organization requires another study in itself. Thus, the data gathered for this preliminary study, focuses on those elements of uncertainty that are easily observed and that were willingly reported.

Uncertainty: Problems

The questionnaire sent to the communities in this study contained nineteen items relating to problems with environmental elements. These were divided into the five categories: federal, state, and county level regulatory agencies, suppliers, and an "other" category consisting of the parent cooperation, resident association, and employee unions. At each level respondents were given the opportunity to identify problem sources that were not already listed.

The officials of the communities were asked to identify organizations that, in the past year, were the sources of problems serious enough to require a response by the community. Table 22 presents the results both in percentages and in actual number of responses.

In addition to the survey data, the in-depth interviews were used as a means to gather information

Table 22
Sources of Problems for Florida's Continuing
Care Retirement Communities.

	Environmental Element	Percent	Actual Number
Regulators:			
Federal	Housing and Urban Development.	9.8%	4
	Social Security.	17.1%	7
	Medicare.	39.0%	16
State	Department of Health and Rehabilitative Services.	75.6%	31
	Department of Insurance.	65.9%	27
	Medicaid.	43.9%	18
County	Health Department.	29.3%	12
	Business License.	9.8%	4
	Zoning Commission.	17.1%	7
Suppliers:			
	Medical.	29.3%	12
	Food.	36.6%	15
	Office.	22.0%	9
	Contractors.	24.4%	10
Others:			
	Parent Corporation.	22.0%	9
	Resident's Asso.	39.0%	16
	Employee Unions.	4.9%	2

concerning the types of problems that a community was likely to encounter from each of the environmental elements. Those data are incorporated into the discussion that follows.

Given the rather distant relationship between the federal regulatory agencies and the communities in this study, it is not surprising to find that fewer than twenty percent reported that they had encountered problems with either the Department of Housing and Urban Development (9.8%) or the Social Security Administration (17.1%). This is as expected, because of the very limited involvement of HUD discussed earlier, and the fact that the social security administration is only indirectly involved through the nursing home component and the individual residents who receive benefits.

Medicare was purposely listed separately, although technically it is a part of the social security program, because of the fact that reimbursements to facilities providing health care to older people are determined by the medicare administration. Since this has a direct impact on the types and quality of service that continuing care communities can offer, it is not surprising to find that almost forty percent (16) of the communities listed medicare as a source of serious problems.

Also listed as a separate category is medicaid. Although it is subsidized by and administered through the state agencies, medicaid remains essentially a federal

program. Its impact on the communities in this study is related to the nursing home services that are provided. Again, a substantial number of the communities responding to the survey (43.9%) listed those responsible for the administration of the medicaid program as a source of problems.

Perhaps the most serious source of environmental uncertainty, as indicated by problems, comes from the state regulatory agencies. This is due, in part, to the direct nature of the regulatory relationship at the state level and in part due to the risk involved. As mentioned before, the primary responsibility for regulating continuing care retirement communities on the state level is vested in the Department of Health and Rehabilitative Services (HRS) and the Department of Insurance (DOI).

Slightly over seventy-five percent (31) of the responding communities reported that HRS was a problem source in the past year and about sixty-six percent (27) reported that the DOI was a problem source. The interview data suggest that the state regulatory agencies are not only the primary sources of problems for these communities, but dealing with these agencies also contains the highest element of organizational risk.

In any situation of high risk one can expect much organizational effort is expended in attempting to minimize the potential impact of that risk. That effort can take either an anticipatory or a reactive form. In

this case, continuing care retirement communities often concentrate the responsibility for monitoring, communicating, and reacting to the elements of the state regulatory environment in one position, usually the executive director or general manager. In fact, in at least three cases, the only formally established duties of the executive officer of the organization were to act as a buffer and information source between the state regulatory mechanisms and the community.

Another important source of problems for these communities appears to be the county level regulatory agencies. About thirty percent (12) of the communities reported that they had experienced a problem with their county health departments in the past year. These problems tend to be related to the delivery of food services and they are usually of only minor importance in that there is little threat to the welfare of the residents. Still, because food service is such an important part of the overall package of services that these communities offer, any problem has an element of risk for the organization.

Suppliers make up the remaining problem source category. And the data suggest that, depending on the type of supplier being considered, between about twenty percent (8) and about thirty-five percent (14) of the communities have had problems with their suppliers.

Obviously the two most important suppliers in any continuing care retirement community are the food

suppliers and those who provide medical supplies. Problems related to this category are usually confined to what one would normally think of as general business dealings. Because of the relatively superior power of the communities with respect to the individual suppliers, which is partly due to the large number of alternatives that exist, problems here represent little more than annoyances for the officers of the organizations.

Still, the potential for much more serious problems exists if the normal problems associated with the day-to-day business dealings are not satisfactorily dealt with soon after their discovery. This is particularly true in cases where the community is relatively isolated in a rural area and the number of alternative suppliers is low.

Although the number of cases is small, the data suggest that the more rural communities concentrate more organizational energy into their dealings with suppliers than do the communities located in more urban areas.

Uncertainty: Relationship

Another component of environmental uncertainty involves the relationship these communities have with the elements of their task environments. Respondents were asked to indicate the relationship, as measured by five choices, between their organization and selected organizations in their environment. Although the concept of organizational "problems," explored in the previous section, and the idea of "disputes or disagreements" are related, there is a qualitative difference between the

two. The less value laden term "problem" could be any situation requiring organizational energy. The intentionally value laden concept of "dispute," on the other hand, specifically and intentionally connotes a correct and an incorrect "side" to any particular situation. Thus, while all disputes could reasonably be classified as problems, not all problems are disputes.

Table 23 presents the data on the relationship between the continuing care retirement communities in this study and selected environmental organizations. As might be expected, in light of the discussion above, there are few disputes with federal regulatory agencies.

Except for the medicare administration, about ninety percent (37) of the communities reported that they had no disputes with either HUD or the Social Security Administration. Thirty-four percent (14) reported that they had a "few" disputes with the medicare administration. These disputes are probably related to the levels of reimbursements for health related care delivered to the residents and usually involve well established appeals mechanisms that do not require much organizational effort or time.

State regulatory agencies present a more serious level of dispute to these communities if only because the state regulatory agencies are responsible for enforcing state statutes related to the day-to-day operation of the

Table 23
Relationship of Florida's Continuing Care Retirement
Communities with Elements in Their Environments.

Environmental Element	Frequency of Disputes*					
	a	b	c	d	e	f
Regulators:						
Housing and Urban Development.	90.2%	4.9%	0%	0%	0%	4.9%
Social Security	90.2%	9.8%	0%	0%	0%	0%
Medicare.	63.4%	34.1%	0%	0%	0%	2.4%
Health and Rehabilitative Services.	26.8%	65.9%	7.3%	0%	0%	0%
Department of Insurance.	29.3%	68.3%	0%	2.4%	0%	0%
Medicaid.	51.2%	43.9%	0%	0%	0%	4.9%
Health Department.	78.0%	22.0%	0%	0%	0%	0%
Business License.	95.1%	2.4%	0%	0%	0%	2.4%
Zoning Commission.	87.8%	9.8%	0%	2.4%	0%	0%
Suppliers:						
Medical.	51.2%	43.9%	4.9%	0%	0%	0%
Food.	39.0%	46.3%	14.6%	0%	0%	0%
Office.	73.2%	24.4%	2.4%	0%	0%	0%
Contractors.	51.2%	41.5%	2.4%	0%	0%	4.9%
Others:						
Parent Corporation	75.6%	12.2%	2.4%	0%	0%	9.8%
Resident's Association	58.5%	41.5%	0%	0%	0%	0%
Employee Unions.	68.3%	0%	0%	0%	0%	31.7%

*Frequency of Disputes Legend:

n=41

a=Never

b=A few disputes

c=Disputes are common

d=Disputes are frequent

e=Disputes are constant

f=No response

communities. Unlike the other regulatory categories, the state mechanisms have a direct impact on every aspect of the organization's operation. For that reason, communities tend to place more emphasis, and expend more energy, on the disputes with the state regulatory agencies.

Due, in part, to the expanded domain of these state agencies, one would expect that more communities would report disputes with the state agencies than with the others. This is the case for the communities in this study. About sixty-five percent (27) reported that they had experienced a few disagreements with HRS. Another seven percent (3) reported that disputes with HRS were common.

As expected the communities report much the same pattern for their relationship with the DOI. Sixty-eight percent (28) reported that they had had a few disputes with the DOI and one community reported that these disputes were frequent.

The county level regulators seem to have the least troublesome relationship with these communities. In fact, none of the communities reported frequent disputes and only a few reported any disputes. As can be seen in Table 23, the percentages for the health department, the business license bureau, and the building or zoning commissions are small indeed.

Suppliers represent the second most important group of environmental organizations. Clearly, as the data in

Table 23 suggest, food suppliers, medical suppliers, and contractors and builders require some amount of organizational effort to address disputes.

In the case of food suppliers, about forty-six percent (19) of the communities reported that they had experienced a few disputes while about fourteen percent (6) reported that disputes were common. The data are similar for the other two groups with the exception that fewer communities (4.9%) report that disputes are common.

There is one other category reported in Table 23 that should be pointed out. About forty percent (17) of these communities reported that they had experienced a few disputes with their resident's association. Most continuing care retirement communities encourage the formation of resident's associations. Functionally, this has the effect of providing a formal basis for a relationship between the organization and the residents. It also tends to concentrate both the disputes and the number of people involved such that, organizationally, monitoring, reaction, and prediction are made easier. Thus, while the report of frequent disputes with the resident's associations of these communities might be due to a poor working relationship between the two, it might also be an indication of a well designed grievance procedure that is operating as it was intended to operate.

An important additional element to understanding the relationships involved here, is the basis for disputes

between the communities and the organizations in their environments. Respondents who had indicated the presence of disputes were asked to indicate the basis for those disputes as well. Table 24 presents the results.

Based upon data gathered in the interview portion of this study, five categories describing the basis of disputes were identified. Those categories along with an "other" option were presented as a forced choice question.

The data concerning the federal regulatory agencies suggests that whatever disputes exist, they are related to the day-to-day operation of the community and require little more than specific attention to clearly defined disputes. The interview data further suggest that clearly defined disputes usually imply their own solution such that the officials of these communities spend little time in responding to disputes with the federal regulatory agencies.

The same is not true of the state regulatory agencies. Disputes with these environmental organizations tend to be in the form of directives requiring at least written proof of compliance. Even when community officials comply without contesting the issue, much effort is needed to respond adequately to the directive. In addition, when the officials contest these directives, although the procedures are well defined, the actual content of the appeal is not. Thus, much effort is expended in formulating the reply.

Table 24

The Basis for Disputes Between Florida's Continuing Care Retirement Communities and Elements in Their Environments.

Environmental Element	Basis for Disputes*				
	a	b	c	d	e
Regulators: Housing and Urban Development.	95.1%	2.4%	0%	2.4%	0%
Social Security.	82.9%	14.6%	0%	2.4%	0%
Medicare.	65.9%	24.4%	4.9%	2.4%	0%
Health and Rehabilitative Services.	22.0%	51.2%	9.8%	14.7%	2.4%
Department of Insurance.	34.1%	46.3%	9.8%	7.3%	2.4%
Medicaid.	56.1%	31.7%	2.4%	9.8%	0%
Health Department.	73.2%	17.1%	0%	9.8%	0%
Business License.	92.7%	7.3%	0%	0%	0%
Zoning Commission.	85.4%	14.6%	0%	0%	0%
Suppliers: Medical.	48.8%	31.7%	9.8%	9.8%	0%
Food.	36.6%	36.6%	4.9%	14.6%	7.3%
Office.	65.9%	29.3%	2.4%	2.4%	0%
Contractors.	65.9%	22.0%	2.4%	7.3%	2.4%
Others: Parent Corporation.	87.8%	4.9%	4.9%	2.4%	0%
Resident's Asso.	51.2%	36.6%	9.8%	2.4%	0%
Employee Unions.	100%	0%	0%	0%	0%

*Basis for Disputes Legend:

a=No disputes

b=Specific causes related to day-to-day operation

c=Different operating philosophies

d=Lack of communication

e=Difference in power

As Table 24 indicates, the reported basis for disputes between the communities and the state regulatory agencies is varied. While about fifty-one percent (21) of them report that the disputes with HRS are related to the day-to-day operation of the community, as would be expected. Another ten percent each (4) report that the disputes are due to different operating philosophies and lack of communication. Similar data are reported for disputes with the DOI.

The issue of different operating philosophies is an interesting one. In the interview portion of this study, officials at two communities expressed the opinion that the state regulatory agencies did not necessarily operate in the best interests of the residents. In each of these cases the official believed that the community organization itself was more interested in the welfare of the residents than were the state regulatory agencies. As one official put it; "all they care about is their rules and they (the rules) don't have much to do with getting old."

This conversation points out an important but often overlooked element that is fundamental to the regulatory relationship. That is, continuing care retirement communities are primarily interested in providing a lifestyle (the end), while the regulatory mechanism is primarily interested in how that lifestyle is provided (the means). The difficulty lies in the perception of each

organization by the other organization. Since the state regulatory agencies have, in general, an adversarial relationship with these communities, in an attempt to eliminate the possibility for abuse, they tend to suppress innovative opportunities to serve the residents better. Similarly, and because of the same relationship, the communities, in an attempt to survive, cannot pay as much attention to the the spirit of the regulatory process as to the letter of that process. In both cases it is the residents who lose.

Uncertainty: Communication

Communications plays an important role in the relationship between and within organizations. To better understand the operating environment, and thereby reduce uncertainty, at least some acceptable level of communication with elements in the environment is necessary. Logically, the better the communications between elements, the more complete the information and the easier it will be to predict changes.

Respondents were asked to rate the quality of communications between their particular community and selected environmental organizations. Table 25 presents the results.

As is indicated by Table 25, the communications between the federal regulatory agencies and the communities is listed as "adequate" or better by a majority of the communities. When poor levels of communication are indicated, the percentages tend to be

Table 25

Quality of Communication Between Florida's Continuing Care Retirement Communities and Elements in Their Environments.

Environmental Element	Quality of Communication*					
	a	b	c	d	e	f
Regulators:						
Housing and Urban Development.	0%	0%	17.1%	9.8%	4.9%	68.3%
Social Security.	2.4%	4.9%	36.6%	17.1%	4.9%	34.1%
Medicare.	2.4%	7.3%	61.0%	12.2%	2.4%	14.6%
Health and Rehabilitative Services.	2.4%	22.0%	39.0%	26.8%	9.8%	0%
Department of Insurance.	2.4%	19.5%	39.0%	31.7%	7.3%	0%
Medicaid.	0%	9.8%	41.5%	19.5%	4.9%	24.4%
Health Department.	0%	4.9%	56.1%	34.1%	4.9%	0%
Business License.	0%	0%	51.2%	26.8%	4.9%	17.1%
Zoning Commission.	0%	0%	51.2%	24.4%	9.8%	16.6%
Suppliers:						
Medical.	0%	4.9%	46.3%	39.0%	9.8%	0%
Food.	0%	7.3%	43.9%	36.6%	12.2%	0%
Office.	0%	0%	51.2%	39.0%	9.8%	0%
Contractors.	2.4%	2.4%	41.5%	34.1%	4.9%	14.6%
Others:						
Parent Corporation.	0%	2.4%	17.1%	26.8%	26.8%	26.8%
Resident's Asso.	0%	0%	17.1%	31.7%	46.3%	4.9%
Employee Unions.	0%	0%	4.9%	2.4%	0%	92.7%

*Quality of Communication Legend:

n=41

a=Very poor

b=Poor

c=Adequate

d=Good

e=Very Good

f=No response

small and are probably due to specific and current situations rather than a fair assessment of the overall quality of communications.

Again, the case of the state regulatory agencies is different. Here, the data indicate that about twenty-five percent (10) of the communities have what could be termed less than adequate communications with the state regulatory agencies.

Although there are probably a number of reasons for this, one of the more interesting is that from the perspective of the state regulatory agencies, there is no advantage to maintaining good, or in this case two-way, lines of communications with the communities. There is evidence to indicate that the adversarial relationship mentioned above involves a power differential that, at least from the perspective of HRS and the DOI, would be undermined by maintaining too close a relationship with the officials of the communities.

Put another way, since the state regulatory agencies perceive their communications to the communities, at least the formal written ones, as directives, there would be little advantage, and perhaps some disadvantage, in establishing lines of communications that allowed the communities to anticipate future changes in the regulatory process. However, as the interview data suggest, what is formally, if not intentionally, discouraged is informally pursued. And, one finds a number of communities where the

officials maintain informal lines of communication with what they describe as "friends" within the regulatory agencies themselves.

The data for the quality of communications with suppliers is included in Table 25. The general trend is that the overwhelming majority of these communities maintain what they describe as at least an "adequate" quality of communications with their suppliers. This is not surprising given the potential financial impact of these communities on individual suppliers. In fact, there is strong incentive for the suppliers to establish and maintain the lines of communications with the communities.

Environmental Dependence

Perhaps the single most important aspect of organizational environments is the extent to which the focal organization is dependent upon the environment. Whatever problems that exist, whatever the nature of disputes, and whatever the quality of communications, the extent to which an organization is dependent on the environment dictates the amount of organizational energy that will be expended in an attempt to reduce uncertainty. So important is this concept of environmental dependence that if nothing else is known about an organization, other than the characteristics of its operating environment and the extent to which it depends on its environment, a reasonably clear picture of the characteristics, structural and otherwise, can be constructed.

The questionnaire contained two items related to environmental dependence. One asked for an assessment of the focal community's autonomy in relation to a list of the various organizations in the operating environment. The second asked for an assessment of the power of the communities in relation to the same environmental organizations.

Autonomy is defined as the extent to which one organization is free of the influence of other organizations. Power, on the other hand, is defined as the extent to which one organization can influence another organization. It is obvious that the two concepts are related and that the relationship involves perspective.

As discussed in a previous chapter, power is an assessment of environmental autonomy, when viewed from within the retirement community, and autonomy is organizational power, when viewed from the environment. It was suggested there, and it is restated here, that autonomy implies standing at the center of the focal organization looking outward to assess the influence of the environment and power implies standing somewhere in the environment and looking inward toward the focal organization.

Table 26 presents the results of the survey for autonomy and Table 27 presents the results for power. In the case of the federal regulatory agencies, about half (51%) of the communities reported they were either

Table 26
The Self-Reported Autonomy of Florida's
Continuing Care Retirement Communities Compared
to Elements in Their Environments.

Environmental Element	AUTONOMY			
	Low 1	2	3	High 4
Regulators:				
Housing and Urban Development.	46.3%	14.6%	14.6%	24.4%
Social Security.	26.8%	29.3%	26.8%	0%
Medicare.	31.7%	29.3%	34.1%	4.9%
Health and Rehabilitative Services.	0%	24.4%	51.2%	24.4%
Department of Insurance.	0%	29.3%	53.7%	17.1%
Medicaid.	26.8%	26.8%	29.3%	7.3%
Health Department.	0%	70.7%	26.8%	2.4%
Business License.	14.6%	65.9%	9.8%	4.9%
Zoning Commission.	14.6%	63.4%	9.8%	4.9%
Suppliers:				
Medical.	70.7%	24.4%	2.4%	0%
Food.	70.7%	24.4%	4.9%	0%
Office.	73.2%	26.8%	0%	0%
Contractors.	65.9%	22.0%	2.4%	0%
Others:				
Parent Corporation.	12.2%	29.3%	24.4%	14.6%
Resident's Asso.	7.3%	58.5%	26.8%	7.3%
Employee Unions.	26.8%	4.9%	0%	0%

n=41

Table 27
The Self-Reported Power of Florida's Continuing
Care Retirement Communities Compared to Elements
in Their Environments.

Environment Element	POWER				
	High 1	2	3	4	Low 5
Regulators:					
Housing and Urban Development.	0%	2.4%	0%	31.7%	22.0%
Social Security.	0%	7.3%	4.9%	39.0%	29.3%
Medicare.	0%	12.2%	14.6%	36.6%	26.8%
Department of and Rehabilitative Services.	2.4%	0%	14.6%	48.8%	31.7%
Department of Insurance.	2.4%	4.9%	14.6%	51.2%	22.0%
Medicaid.	0%	4.9%	9.8%	41.5%	22.0%
Health Department.	0%	17.1%	26.8%	46.3%	9.8%
Business License.	2.4%	24.4%	22.0%	36.6%	9.8%
Zoning Commission.	2.4%	24.4%	24.4%	31.7%	9.8%
Suppliers:					
Medical.	51.2%	26.8%	14.6%	4.9%	0%
Food.	53.7%	24.4%	14.6%	2.4%	4.9%
Office.	53.7%	24.4%	14.6%	2.4%	4.9%
Contractors.	46.3%	19.5%	12.2%	4.9%	2.4%
Others:					
Parent Corp.	2.4%	4.9%	29.3%	24.4%	12.2%
Resident's Asso.	7.3%	22.0%	56.1%	7.3%	2.4%
Employee Unions.	0%	7.3%	0%	0%	0%

n=41

completely autonomous or that specific regulatory agencies had some influence on their operation. Similar results were not obtained in the case of the concept of power. Here, a much larger percentage of the communities reported that they were not as powerful as the federal regulatory agencies. (Note that the percentages reflect the percentage of the total communities, i.e., 41, and not only those not choosing the category; "cannot make a judgment." Those choosing the latter category were less than ten percent (4) of the communities).

These results are consistent with the earlier contention that the influence of the federal regulatory agencies tends to be perceived as indirect. The overall picture is that although the officials of the communities perceive their organizations to be less powerful than the federal regulatory agencies, they also clearly perceive their operation to be autonomous. Put another way, these results could be interpreted as an indication that the federal regulatory power is viewed as potential power that remains largely unexercised in day-to-day life.

Again, the situation is quite different for the state regulatory agencies. Not only do the officials of these communities perceive that their communities are influenced by the state regulatory agencies, but they perceive these agencies to be more powerful as well. In the case of the DOI, one would expect the respondents to perceive a good deal of influence. That is the case with about seventy

percent (29) reporting that their community was not autonomous in relation to the DOI and ninety-seven percent (40) of them reporting that they felt their communities were less powerful than the DOI. Similar, although smaller percentages, were obtained for the relationship with HRS.

These results would be consistent with the idea that state regulatory agencies represent a more direct form of control that is actually exercised rather than being only a potential for influence. A similar interpretation can be given to the data reported for the county level regulatory agencies. Note, however, the perceived relative power of the county health departments. While about seventy percent report that they operate autonomously with respect to the health departments, only about seventeen percent judge their actual power to be superior to the health departments. Again, a potential but largely unused basis for influence is suggested.

If the interpretation of the relationship between power and autonomy is correct, one would expect that, given the number of alternative suppliers available to the communities, the officials would report both autonomy from and power over the suppliers. That is indeed the case. For example, for medical and food suppliers, there are only two communities that reported a lack of autonomy and these same communities reported that the suppliers enjoyed a relative power advantage.

Summary

One of the primary difficulties in any analysis that proposes to take into account elements in the operating environment is that it must immediately confront the problem of selecting elements for exploration. That problem is made easier by conceptualizing the environment as a series of "task" environments.

Put simply, organizational environments can be sorted on the basis of important goal directed tasks that the organization has set for itself. Implied in this construction is that the more important the task, the more important the elements in that particular task environment.

In an adaptation of Dill's (1958) four task environments, the continuing care retirement communities studied here were found to have five different and important task environments. The five are labeled; regulators, constituents, suppliers, competitors, and a residual category containing such things as the financial and social impact of the retirement community on the surrounding community and the cultural norms associated with the physical area.

As might be expected, regulators were found to be the most problematic and, in that sense, the most important of the task environments. Specifically, the state regulatory agencies were particularly problematic. And, because of the risk involved and the somewhat adversarial

relationship that exists between state regulatory agencies and the communities, much organizational effort is expended in monitoring and responding to those agencies.

The constituents also represent an important environmental element. Here, unlike most gerontological research, the constituents of these communities include the employees as well as the residents. It is suggested that the organization is different for these two groups.

Specifically, it is suggested that there exists a special relationship between the community as an organization and the residents such that the residents are a decision-making part of the organization and a part of the environment at the same time. The only way to judge the impact of the residents is to take a relativistic perspective. From the perspective of the residents the employees, with the exception of the upper level employees, are a part of the operating environment. Similarly, from the perspective of the employees the residents are an environmental element.

Suppliers are also an important part of the environment, but because of the relative power advantage of the communities, little effort is made to predict the impact of suppliers. In fact, due in large part to the many alternatives that exist, most of the suppliers will go to extraordinary lengths to maintain a good working relationship with these communities.

Competitors are also an important element in the environment, however, partly because of regulation, there is a distinct cooperative character to dealings between competitors in this industry. What direct competition there is, is usually confined to very similar communities in the same general geographic area.

Finally, the residual category is ill-defined but very important. Particularly in rural areas, the impact of a retirement community in terms of social norms and in terms of economic expenditures can be profound. In many instances, it is the retirement community that is the areas largest employer and any decisions made concerning the extent or intensity of services can have a great impact on the surrounding community.

Environmental uncertainty is a problem only to the extent that an organization is dependent upon a particular element. In the case of continuing care retirement communities, it would appear that the greatest uncertainty and the greatest risk is associated with the two state level regulatory agencies.

CHAPTER TEN SUMMARY AND CONCLUSIONS

This dissertation addresses two primary objectives. First, it identifies the rather complex organizational and environmental components of Florida's continuing care retirement communities. Secondly it lays the groundwork for the development of a conceptual and research framework to guide further study of this somewhat unique phenomenon.

As was noted in the introductory chapter, there is some disagreement over whether these age concentrated communities are socially desirable. This argument, albeit more an intellectual exercise than a full blown argument with practical implications, is based largely upon the age segregation that is implied by the general concept of non-traditional housing for the elderly. However, there is little disagreement among gerontologists that these communities, as well as other non-traditional living arrangements are, and in all likelihood will remain, an important component in the way elderly people choose to house themselves.

Whichever side of the argument one takes, there is a need for basic information about just how non-traditional living arrangements operate. Specifically, the clear

tendency has been to study the residents themselves and to judge the overall quality of the lifestyle by the personal adaptation and adjustment of the individuals who live in them.

This is undeniably a vital area for continued research, and it is in no way being suggested here that it is not. However, it is being suggested that there is another, equally important, area of research that has, until very recently, been largely ignored. That area includes the structural and organizational characteristics of these living arrangements as well as the relationships between and among the elements in their operating environments. And, that is the area to which this dissertation is directed.

Summary of the Findings

The continuing care retirement community did not become a widely accepted living arrangement until roughly the mid to late 1960s. Before this, what communities there were tended to be affiliated with religious or fraternal organizations and tended to offer retirement living exclusively to retired members of the sponsoring groups.

As entrepreneurial developers became interested in building communities for the growing population of elderly people who had both the good health and the financial resources to live in age concentrated non-traditional living arrangements, there began to emerge an "industry"

whose primary function was to build and operate these communities. This industry was, in its infancy, viewed by policy makers and consumers alike as nothing more than an extension of the more traditional housing industry.

However, the well documented and regrettable failure of some of these early attempts at providing lifelong care to elderly people (Williams, 1985; Morrison et. al., 1985; Winklevoss, 1986; and Lane, 1985) made it apparent that these communities were indeed not merely a subcategory of the traditional housing industry. Rather, they represented an altogether different category with a separate set of responsibilities and problems that required regulation.

Whether the abuses were the calculated product of nefarious individuals, as is suggested by Williams (1985), or whether the abuses were the result of neglect by those inexperienced in providing these types of services as an integral component of housing is a matter of perspective and is, in an absolute sense, largely irrelevant. The consequences of that abuse, however, are vitally important. Because of these failures the wide-spread adoption of continuing care as a non-traditional living arrangement demanded, and received, attention from the various state regulatory mechanisms.

Regulation had the immediate and profound impact of taking these communities out of the realm of a largely informal and altruistic expression of fraternal or religious affiliation and making them businesses and, more

importantly, formalized businesses. No longer were the professed ideals of those who operated these communities the primary criteria for judging the worth of a particular lifestyle. Regulation brought with it minimum performance standards and rules designed to protect both the potential residents and operators of the communities.

Whatever else regulation has meant to the continuing care industry, it has meant that a "market package" of services has developed that is, more or less, standard. And that, in turn, has meant that the organizational components as well as the environmental diversity of these communities is strikingly similar.

Organizational Elements

One cannot discuss the organizational characteristics of continuing care retirement communities without also taking into account the residents, the physical structures, and the living arrangements found in these communities.

The residents of these communities are primarily in an age category that gerontologists like to call the "old-old." Among the forty-one Florida communities responding to this survey, the weighted average age of the residents was about eighty-one years old. Clearly these are people, probably widowed women, who are more frail than their younger counterparts. In addition, although the anticipation of future health care needs remains a

powerful attraction for potential residents, those who now live in these communities are likely to actually need support services at the present time.

The implication of the age characteristics and types of services that are available is that these communities are not filled with relatively healthy people who only believe they will need services in the future. Rather, they are filled with people who, in large part, actually need those services at the present time in order to meet the requirements of day-to-day life.

Although the actual physical structures within which these communities are housed vary widely in terms of quality, size, and luxuriousness they usually consist of one or more multi-story units and a single story nursing home component. If there is a general characteristic underlying the physical structures of these communities, it is that the dwelling units and the communities as a whole are relatively compact. The apartments tend to be small and functionally uncomplicated.

A reasonable interpretation of this is that the entire lifestyle is designed to be functionally uncomplicated and is centered around the support services that are available. Thus, the actual physical surroundings are less important than the services that are available, and that is reflected in the relative austerity found in some of the individual apartments.

There are three basic lifestyles offered by continuing care retirement communities. These are

independent living, assisted living, and supervised living. As was suggested, the living arrangements, housing types, and, service types are all interrelated such that residents and others may judge functional ability on a combination of factors relating more to one's position within these three categories than on his or her objective functional ability.

In fact, this area suggests itself as an important and interesting area for future research. It is especially promising for sociologists, since it deals with the subjective meaning that an enclosed and somewhat self-contained society attaches to a combination of living arrangements, housing types, and service types.

Also of interest are the social exchange mechanisms that combine to place a particular resident in a particular living arrangement, located in a particular housing type, and consisting of a particular array of services. For example, it would be of interest to gerontologists, particularly those from a sociological background, to make an assessment of how structural variables, in the sociological sense, impact upon decisions about a particular resident's placement within the community. Put another way, sociological questions concerning who gets favored treatment and why become especially important in the context of a reasonably self-contained "society" with a population that is, in a very real sense, isolated from the larger society. In addition,

the residents of these retirement communities tend to be more homogeneous in terms of their economic and health status than the general population of elderly people.

The sociological issue here is much more important than mere answers to puzzling questions about retirement communities. For regardless of the answers, something important is learned. For example, Streib (1985), noting that social stratification is "probably as old as culture" (p. 340), has called attention to the mechanisms of stratification that exist within the population of people usually heaped together in the category labeled "elderly." He further asserts that

The universality of social stratification leaves open the question of which criteria are to be employed in sorting out the strata and classes in a given society. (p. 340)

If the criteria for placement within the social organization of a retirement community is based upon factors other than those normally associated with stratification, i.e., socioeconomic status, or, in the case of elderly people, former socioeconomic status (Riley, 1976; Palmore, 1971), then these communities offer a rare opportunity to conduct the "natural experiment" that was hinted at by Durkheim (1982, p.147-148) and formalized by Chapin (1955).

If, on the other hand, no alternative criteria for stratification can be discovered, then something important is learned about the elderly as a subgroup, or subculture (Rose, 1980), of the larger society.

Some of the possibilities are intriguing even if they are yet to be explored systematically. For example, in one of the retirement communities included in the study by Streib, LaGreca, and Folts (1986), the field researcher noted that the residents in one very exclusive community were extraordinarily similar with respect to most relevant social variables. In effect, there were no easily detectable differences by which residents could judge the relative merits of each other.

It was suggested independently by several of the informants that positions of esteem within the community were based upon elected positions in the resident's association, and election to these positions was related to golf scores. Generally, it was reported, the lower one's golf scores the more prestigious the position one was qualified to hold. An informal exploration into the records of that community revealed that indeed the past four presidents of the resident's association had also won the community wide golf tournament the year prior to their election.

It was also suggested by the informants that the responsibilities of office took time away from golf which resulted in higher scores. That in turn resulted in the incumbent losing the next election. In fact, although it is impossible to assign any causal relationship, the records did show that none of the past four presidents had won the tournament the year after their election, and none of them had been reelected to office.

It is this type of pattern, anecdotal though it may be at this point in time, that should excite even the most staid sociological gerontologist. What if, for example, in continuing care retirement communities, health is a substitute variable by which the social worth of the individual residents is judged. If, as we have suggested here, there is a relationship between housing type, living arrangement, and service type, those who make the decisions about where an individual is placed in the community would then have extraordinary power determining the social position of that person.

Unfortunately, these questions and others like them must remain unanswered, at least for the present. They are quite beyond the scope of this dissertation and can be pursued only after preliminary research such as this is completed and then replicated on a considerably more ambitious scale.

Unlike the early continuing care communities in Florida, those established after the early to mid 1960s offered what has been described here as a "market" package of services. While the early communities were dedicated to the more or less informal delivery of a wide array of services based upon resident need, the later ones were more formal and more limited in their service delivery possibilities.

This formalization and specification of services is attributable to the tightening of regulatory statutes and

to the recent legalization of the heretofore paternalistic relationship that existed between the residents and the communities.

The overall effect of this has been that, from the perspective of the residents, continuing care retirement communities now offer a package of services that can be divided into the categories of housing services, nutrition services, personal services, and social services. Within each of these categories there are specific services that are related to the individual residents.

Organizationally, the types of services are related to the structural components. Generally, the communities in Florida, and it is assumed elsewhere as well, have divided their organizational structure into departments that are related to the types of services offered. Thus, there are usually separate departments responsible for the delivery of services related to maintaining the physical structures, the delivery of meals, the planning of activities, and the delivery of the broad category of health related services.

In addition to these, most of the communities have a separate department for financial and accounting tasks and general office services. This produces a structural profile consisting of five departments; social services, food services, building services, health related services, and, accounting and financial services.

Although this last one is not directly involved in the delivery of services to the residents, each of the

departments is individually responsible for a single element in the service package. And, all contribute to the generally supportive environment created by the continuing care concept and to what we have called the reasonable expectation of lifelong care.

Another important finding is that the hierarchical dispersion of these communities is similar. While there is some variation in the number of levels within the organizations, except in extraordinary cases, there are generally only four levels in their organizational hierarchies. A typical community has a board of directors, an executive director or general manager, heads of various departments, and lower level employees who actually deliver the services to the residents.

Decision making power, as would be expected, is concentrated in the upper levels of the organization. However, the data indicate that the executive directors or, as they are called in some communities, the general managers, appear to have extraordinary decision making powers in matters related to the day-to-day operation of the community. In fact, one is struck by the low level of involvement of some of these boards of directors.

This is especially interesting in view of the fact that it is these boards of directors which bear both the regulatory responsibility and the ultimate legal liability to provide a milieu that is, at its very worst, benign and at its very best, salubrious. Despite that, the typical

board seems to invest in its executive director broad powers in operating the community.

A related issue is what organizational researchers call spatial dispersion. Put simply, spatial dispersion implies decision making at a distance. Based upon the discussion above, it is not surprising to find that, in the continuing care retirement communities studied here, there appears to be little spatial dispersion in their operation. Decisions seem to be made at the local level. That is, at an organizational level physically located at or near the actual delivery of services. As was mentioned above, that level is the general manager's level.

This general characteristic appears to hold even among the communities that have an affiliation with a larger organization. Except for a very few instances, affiliation with another organization has little practical impact and almost no discernible qualitative benefit.

Still, there are a few communities that remain committed to admitting only members of certain religious denominations or fraternal organizations. These, however, tend to be relatively small communities that were established long before the 1960s and thus avoided the more recent legislative and economic trends that made such communities largely unfeasible.

Environmental Components

The task environments of continuing care retirement communities are interesting, in and of themselves, because

the very nature and purpose of providing services to individuals who are in the age group referred to as "old-old" involves a considerable amount of uncertainty. This, in turn, implies that some attempt is made to reduce that uncertainty through predictive mechanisms.

Although neither uncertainty nor attempts to reduce it were measured in any precise way, nor could they be in this preliminary research, there is a strong indication that environmental uncertainty is indeed an important factor and much organizational time and effort is expended in an attempt to anticipate changes in the environment. The data, both interview and survey, also clearly suggest that some communities are better at anticipating environmental demands than others.

Interesting, although only touched on in this study, are the actual predictive mechanisms themselves. There appears to be wide variation in the way these communities approach environmental uncertainty. In some communities, such as Pine View Village, the mechanisms of prediction are both well developed and formalized to the extent that careful and detailed data on the resident population are kept and constantly scanned for clues to potential problems. Similarly, legislative reports, regulatory agency newsletters, and actual proposed legislative and regulatory changes are compiled and carefully analyzed by the upper level executives in an attempt to gain predictive power.

In other communities, the predictive mechanisms are less well developed and are largely a matter of experience. That is, these communities seem to rely on the belief that future environmental demands will be no different, substantively at least, from past environmental demands. Further, this approach implies that communities such as these rely on adaptive mechanisms that were, more or less, successful in the past, to meet present and future environmental changes that may be quite different in character.

The more serious problem suggested by all of this is that some continuing care retirement communities are facing uncertain environmental demands with rigid and inflexible adaptive mechanisms. Thus, the very survival of some of these communities may be based upon the assumption that the environment will be relatively stable, or constant, over long periods of time. In any sense of the phrase, that is a high risk assumption.

The idea of task environments in organizational research is, like the continuum of care, nothing more than a conceptual tool by which researchers group complex phenomena into similar categories in an attempt to aid understanding. Indeed, it is unlikely that many of those responsible for the operation of these communities have ever even considered the concept in this way.

The decision-makers in these organizations are quite busy enough just attempting to meet the day-to-day demands

of operation. They are, in a very real and practical sense, too close to the actual environmental boundaries to notice that the organization and the environment are separate phenomena. Nor would that information help them much in meeting the more or less immediate demands of operating the community.

For example, in the present case, the single most important element in what we as researchers call the environment is the regulatory apparatus set up for the purpose of ensuring minimum standards of operation. Because the relationship between a particular community and this apparatus is in no sense voluntary, nor is it terminable by either party, there is little practical advantage in viewing regulation as anything more than an extension of the organization itself.

In any event, there is a research and theoretical advantage in conceptualizing that which is not within a particular organization itself as consisting of a series of interrelated but distinctly separated groups of elements called "task environments." That advantage is related to the fact that the alternative is an attempt to make sense out of everything not within an organization itself, but without a framework for combining similar elements.

For example, the task environment we call "regulators" is, for all research purposes, made up of organizations that have similar regulatory functions.

However, from the perspective of the community, the Department of Health and Rehabilitative Services and the Department of Insurance are more dissimilar than they are alike. It is only for research purposes that they can be combined into complexity reducing categories. And, we must constantly be aware that empirical and practical reality may have little use for our intellectual constructs.

Thus, task environments are not palpable things in the sense that retirement communities are things. Rather, they are conceptual constructs that guide exploration to collections of important tasks that a particular organization must perform if it is to survive. In the present case, the data suggest that the task environments of continuing care retirement communities consist of five components. These are, in order of importance; regulators, constituents, competitors, a residual category related to the surrounding community, and suppliers.

As mentioned above, the regulators represent the single most important environmental element both in terms of risk and in terms of uncertainty. The relationship between the regulatory agencies and the communities tends to be an adversarial one and thus, contact tends to be initiated by the regulators and also tends to be in the form of directives with little latitude permitted in the response.

The relationship with suppliers, on the other hand, tends to be initiated by the communities. And, because of

the large number of alternatives available, suppliers do not represent a major source of uncertainty for the communities. What uncertainty there is that is related to suppliers tends to be either short term or related to prices for needed materials. The former is not a serious threat to the community, and the latter is only partially related to a particular supplier. The overall result is that little effort at predicting supplier uncertainty is made beyond attempting to project price increases.

Competitors also offer little in the way of environmental uncertainty. This is partly because the number of competitors is limited by the regulatory and certification process. Another contributing factor is that there would seem to be no shortage of potential residents. In fact, many of the communities in this study have waiting lists for persons wanting to move into the community but for whom there is no space currently available.

A residual category is included because of the fact that continuing care retirement communities do not exist in a social vacuum. Rather, they are a part of a larger community from which residents and employees emerge and into which financial and cultural resources are injected. Depending on the location, a surrounding community can be a source of uncertainty or a source of stability. Because of this, any attempt at understanding any type of retirement community, continuing care or otherwise,

requires that what has been called the "external community" (Streib, et.al., 1984) be taken into account.

Finally, the task environment referred to here as the constituents is an important one. Constituents consist of both employees and residents. It is easy to see that employees of continuing care retirement communities are indeed "members" of the organization.

Less apparent is the fact that residents are also, in one sense, "members." The legal relationship that exists between the community and the residents means that the residents can be viewed as a part of the task environments in most cases. However, in the special case of life care communities, or in those where the residents actually own the corporation that provides the services, which by the way is an increasingly popular means of financing these facilities, the residents are also a part of the organization.

Thus, for constituents, care must be taken to recognize their environmental impact as well as their internal organizational impact. This duality implies, metaphorically at least, that a portion of the operating environment is actually located within the focal organization itself.

To further complicate matters, employees also present a dual character. They are undeniably "members" of the focal organization. Individually they provide the expertise and the physical power necessary for the focal

organization to function and, as a part of their responsibilities, at least at some level they make decisions. However, as a group, they also represent a potential source of uncertainty and from the perspective of the higher levels of the hierarchy, they represent an element of the environment.

It is clear that the linkages between these communities and the elements in their environments are complex indeed, both in terms of their variety and in terms of the ways they interact with any particular community. Further complicating the issue is the fact that each of the elements also interacts with other elements in the operating environment. And, these secondary linkages can be as important as the primary ones.

For example, at the very foundation of regulation is the legislative process. The state regulators, such as the Departments of Health and Rehabilitative Services and of Insurance, are, in this sense, merely extensions of the fact that the state legislature deems certain regulatory initiatives necessary.

Not only that, but whatever power accrues to the regulatory agencies is the direct result of the legislature granting a particular power to a particular agency. Now, the residents of continuing care retirement communities, the employees, the developers, the owners, the sponsoring organizations, the executives, and even the general public, who by the way make up the other elements

in any of the task environments, can all have an impact on the legislative process. And, the weight of their impact may be determined by factors that are quite removed from the delivery of services to the residents.

Thus, what is among the most important environmental elements for these communities, the regulators, is in fact the end result of a very complex set of exchanges between elements of the regulator's task environments that include the residents, the employees and the very organizations that are being regulated.

It is not the intention here to overemphasize the "exchange" nature of the interrelationships between and among the elements in the environments of these communities, although from a sociological perspective it certainly presents itself as a potentially fruitful direction for further research. Rather, the concept of "exchange" is used here to point out the complexity and the richness of those relationships.

The relationship between any organization and other organizations in its environment implies the concepts of power and autonomy. As was discussed in a previous chapter, these two concepts are closely related. In fact, the only real differences between them are differences of perspective. Thus, autonomy is the ability of one organization to act independently, and power is the ability to influence other organizations or, in one sense, to inhibit the autonomy of another organization.

Power is a more abstract concept than autonomy and is thus much more difficult to detect. This is partly due to the fact that power is only apparent when it is exercised and potential power is sometimes more influential than real power. In addition, it is possible to feign power for long periods of time. Complicating the issue is the fact that if no explicit action is made necessary, feigned power and potential power are indistinguishable.

Autonomy, on the other hand, is more easily detected because the very concept involves action. Although potential autonomy is possible, it is based on past action in that the ability to act independently, the definition of autonomy, implies antecedent action. However, autonomy can also be complicated where independent action has never been necessary.

Thus, it is not at all surprising to find that among the communities in this study, the respondents report both autonomy from and inferior power to several of the specific environmental elements. Most notable is the case of the federal regulatory agencies. There is a clear trend for the communities to report that their organizations are less powerful than the federal regulatory agencies while at the same time they report autonomy from their influence.

Based upon the interview data, it is likely that this situation is directly attributable to the lack of close contact with the federal regulatory agencies and the

reliance of those agencies on state regulatory mechanisms for primary regulation of the industry. Put another way, federal regulators tend to be involved only on an issue specific basis, for example the loan guarantees granted by HUD, while state regulators are generally responsible for the actual day-to-day operation of the communities.

A more interesting case is the case of the state regulators. In Florida, continuing care retirement communities are regulated by two main agencies; the Department of Health and Rehabilitative Services and the Department of Insurance. In reference to these two agencies, a majority of the communities report both inferior power to and lack of autonomy.

This, more than any other situation, is a source of both uncertainty and extraordinary risk to these communities. It is thus not surprising to find that the communities, in general, expend much in the way of time, effort, and monetary resources in monitoring, responding, and formulating alternatives to the actions of the state regulatory agencies.

Further Research

Beyond the main findings of this particular study, the intention was to demonstrate a need for further analysis based upon not only the more limited gerontological perspective, but on the organizational perspective as well. The results have shown that, indeed,

by viewing a continuing care retirement community as a synergetic collection of organized components, directed toward what is, more or less, a common goal, the richness of the phenomenon is immediately more apparent. The perspective, in a sense, "opens" one of the "black boxes" that exist in the resident-community relationship.

However, the full contents of this particular "black box" remain largely hidden. First and foremost is the need to gather data from a larger population of communities. This research is based upon only forty-one of a possible sixty-three cases or sixty-five percent of the communities operating in the State of Florida. That number needs to be increased such that relationships between and among important variables may be verified as important.

To do this, it is necessary to study and compare communities in different states and regions of the country. In the present study, although the data were not reported and were used for corroborative purposes only, information from five continuing care communities in California and one in Alabama indicate structural and environmental similarities. These similarities need to be carefully explored for a better understanding of the evolutionary history of these communities.

Another very important issue raised by this study is the relationship between housing type, living arrangement, and service type. Of particular importance is the meaning attached by the residents themselves to the various

possible combinations. If it is the case that one's functional ability is judged by his or her combination of services, housing type, and living arrangement then perhaps more attention, both regulatory and otherwise, needs to be paid to the placement mechanisms that operate within these communities.

There are other important areas of research related to continuing care retirement communities that have only been hinted at here. One area that might be particularly interesting is the structural status inconsistencies, inherent in these communities, between the medical staff and the non-medical executives who are responsible for the day-to-day operation. It would be valuable to explore the behavior of these organizations when the "best" medical decision is not the "best" business decision.

Another area that might be of special interest to gerontologists and commercial developers alike involves the "provisionally licensed" list of continuing care communities. Few of these communities ever actually begin operation but little information is available about the numbers of communities that never open and even less is known about the organizational details concerning the decision to abandon plans for such a community.

Finally, this study indicates that while legal responsibility and ultimate legal liability are vested in the boards of directors, the general managers of these communities have extraordinary discretionary powers with

regard to decision making. In fact, generally, most of the boards of directors are uninvolved in the day-to-day operation of the communities. This suggests an important area for regulatory attention, especially since it implies that those who bear the responsibility are not involved in the decisions.

Conversely, those who make the decisions are not ultimately responsible for those decisions. The phenomenon of "ownership without appreciable control, and control without appreciable ownership" (Berle and Means, 1937, p. 121) has been studied in the context of public corporations and has proven to be important to the understanding of that type of organization. It is likely that the same issue, when fully explored, will prove to be worthwhile in the context of continuing care retirement communities as well.

There is another, largely unintentional and somewhat less obvious, issue that is underscored by this study. There is a tendency to treat conceptual ideas as concrete phenomena. This is especially true of those concepts that simplify otherwise complex situations. Two examples of this are the gerontological conceptual framework referred to as the continuum of care, and the organizational conceptual framework referred to as the environment.

Obviously, neither is a tangible object in the sense that people, bricks, and health care are tangible objects. Less obvious, however, is that neither has any meaning at

all apart from the context of the arrangements of people, bricks, and health care that they are designed to simplify. Put another way, the environmental element "regulators" has no real meaning outside the specific relationship between a specific set of regulatory agencies and the specific communities that they are mandated to regulate.

The most serious difficulty arises when researchers treat the concepts as if they were the actual phenomena under study. It is quite easy, and in some cases quite advantageous, to study the concept "environment" without ever relating it to the actual components that concept represents.

The tendency is to favor what amount to elegantly simple explanations that are logically concise. For example, it would be comfortable if the conceptual framework of a continuum of care was a simple linear relationship between level of care, housing type, and living arrangement. That would satisfy an unmet craving for esthetic simplicity. Yet, as was discussed in a previous chapter, empirical reality takes little note of things that please the viewer.

Again, the problem arises when researchers attempt to force reality into intellectual categories that do not adequately reflect that reality. The solution, however, is relatively simple, for as long as both reader and researcher fully appreciate the distinction between the

reality of a situation and the conceptual constructs created to help make sense of that reality, the difficulty is made less harmful to the analysis.

Organizational Framework

As was noted earlier, a large portion of the research on alternative living arrangements for the elderly has been related to either a direct determination of resident satisfaction, or an exploration of the various service components and their relationship to overall resident satisfaction. Put another way, these studies have attempted to judge how well the needs of the elderly residents are being met by those organizations established to meet their needs.

This type of research is vitally important to understanding what it means to be old in our society and in no sense should the present study be interpreted as a denial of that contribution or as a suggestion that that particular line of research be abandoned. However, it has been established that the residents of these communities are generally satisfied with their lifestyles. Thus, what is being suggested here is that the time has come to look beyond elderly residents for an additional unit of analysis that will expand our understanding and knowledge.

It is specifically suggested here that beyond those residents there exists a collection of organizations that provide the lifestyle and the services that help elderly people meet the demands of personal survival. Further,

it is suggested that these organizations have characteristics that are analogous to a "personality" with needs of its own.

The interaction of the resident's needs and the needs of the organizations designed to meet the resident's needs has produced a large variety of very complex organizations all heaped together in what are called retirement communities. The motivations behind the attempt to provide a safe and healthy living environment for elderly people notwithstanding, the reality of modern life requires the establishment of a complex set of interrelated phenomena acting in harmony toward a general goal if the attempt is even to be made. It is no longer enough that the organizers of these communities simply want to help old people. These interrelated phenomena are what we call organizations and, to the extent that they provide a living arrangement for the elderly, they are largely unexplored.

One of the immediate advantages to shifting the unit of analysis from the residents to the organizational structure itself, is that a more precise definition of performance standards may be formulated. To be sure, performance standards should always be linked to how well a particular community meets the needs of its residents, and in this sense resident satisfaction will always be important but, in the case of retirement communities and especially those that offer health care, there are some

needs that cannot be met. And, any attempt at assessing performance should also take into account the goals of the organizations.

Put bluntly and in the extreme, there is a point at which each resident outlives his or her biological usefulness and dies. Is this to be the criterion by which the successful operation of a retirement community should be judged? Clearly, except in very rare cases, the overall goal of the residents is to avoid death for as long as possible. But the goal of the community is only to provide a safe and more or less health-promoting environment within the limits of financial resources and other factors relating to ability, i.e., technology, competence, and others.

This implies a fundamental conflict between the needs of the resident and the needs of the community. The resident wants as much service as he or she can get for the money spent and the community wants as much money as it can get for the services it provides. One would not think it a fair assessment if the criterion used to judge performance was the amount of money charged for particular services. But, we readily accept criteria based on a subjective assessment of overall satisfaction by those who want as much service as they can get.

It is suggested here that, while both are important, neither is sufficient as a single criterion by which to judge the performance of continuing care retirement communities. What makes both insufficient is the fact that

the very people responsible for the assessment have a vested interest in the results.

From the community's perspective, there are advantages in having the residents believe that neither the intensity nor extent of services can be increased. Similarly, from the perspective of the residents, there is advantage in requesting more service than is currently being provided. Thus, the information one receives, depends, to some extent at least, upon just who one asks.

The problem of assessing performance is only one of many that face those interested in gerontological research. How to define the term "elderly," how to define age related variables, and myriad other related problems all combine to deflect the researcher from his or her main focus of interest.

The larger problem is that the population of people we have chosen to call elderly does not conveniently fit into the rather shallow categories we have created for them. Thus, we pretend that the term "elderly" denotes some form of social solidarity based on age when in fact, as even gerontologists will admit, old people are more diverse and heterogeneous than are young people. How then are we to answer the gerontological question: What does it mean to be old?

It would be auspicious indeed if it were possible to state a clear and simple solution to this set of complex problems. Unfortunately, that is not going to happen here.

But, while the larger context of what it means to be old must await further definition, based upon exhaustive research into many areas, persons interested in that issue must continue to explore old phenomena with new perspectives. Much is known, but much more needs to be known. As our old assumptions and old conceptual schemes are revealed as inadequate, new ones must take there place. It should come as no surprise that organizational analysis is being suggested here as one of those new perspectives.

Organizational analysis should not be treated, in any sense, as an ultimate solution to understanding. However, as a companion research perspective to others that are already well established, it offers a source of additional explanatory power over any of the other perspectives viewed alone.

Modern society has demonstrated that, in more than one sense, organizations have lives of their own that transcend the individuals who comprise them. With respect to other such phenomena, organizations are capable of independent action, goal directed activity, and conscious choice. It makes sense then, if on logical grounds alone, to pursue what is, gerontologically at least, a new level of analysis to discover what can be learned. This dissertation is intended to be a step in that direction.

APPENDIX A
THE QUESTIONNAIRE SENT TO ALL LICENSED CONTINUING
CARE RETIREMENT COMMUNITIES IN FLORIDA

THE UNIVERSITY OF FLORIDA

First, we would like some general background information about this facility. If you would like to make comments on any of the questions or answers, please feel free to use the back of this form. If your organization operates two or more facilities, please make a note of that fact and keep your answers separate where possible.

1. When did the first resident move in ? _____

2. What is the MAXIMUM licensed capacity of this facility?

Residential (or Apartment) _____
Nursing Home (or skilled care) _____
Other (Please specify) _____

3. What is the CURRENT population of the facility ?

Residential (or Apartment) _____
Nursing Home (or skilled care) _____
Other _____
(Please specify) _____

4. When was this facility first licensed ? _____

5. Among the following, which are criteria used in your facility to determine the suitability of potential residents ?

<input type="checkbox"/> Physical health status	<input type="checkbox"/> Religious affiliation
<input type="checkbox"/> Financial status	<input type="checkbox"/> Social skills (ability to get along with others).
<input type="checkbox"/> Family background	
<input type="checkbox"/> Mental health status	
<input type="checkbox"/> Other (Please specify) _____	

6. For those criteria listed in question 5, are they written as formal admission requirements or are they generally "understood" and interpreted on a case-by-case basis ?

☐ Written formal criteria.
☐ Informal largely "understood" criteria.
☐ Other (Please specify). _____

7. Please identify, by title, who determines the suitability of potential residents. (For example: Executive Director, President, Resident's Committee, Admissions Committee, etc.).

8. Are there attempts made to verify the information, supplied by potential residents, on the application for admission ? If so, what attempts are made ?

9. What are the AGE CHARACTERISTICS of the current resident population ?

☐ Average (Mean or Median) age of all residents.
☐ Age of OLDEST resident.
☐ Age of YOUNGEST resident.

10. Are there age restrictions/requirements for potential residents ?

Yes _____

No _____

If yes, what are they ? _____

11. What are the LEVELS OF CARE provided by this facility?
(for example: skilled nursing care; intermediate nursing care; supportive apartment living; independent apartment living; etc.).

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

12. For the levels of care you have listed above in question 11, how many spaces have been allocated for those levels, and how many residents currently occupy those spaces ?

	SPACES	RESIDENTS
LEVEL 1.	_____	_____
LEVEL 2.	_____	_____
LEVEL 3.	_____	_____
LEVEL 4.	_____	_____
LEVEL 5.	_____	_____
LEVEL 6.	_____	_____

13. In your own opinion, what do you think are the most important or valuable services offered by this facility?

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

14. What is the approximate SIZE of the PHYSICAL campus of this facility ? (please include all outside open areas that are a part of the facility). _____.

15. What is the status of the corporation that operates this facility ?

_____ For profit
 _____ Non-profit
 _____ Other (Please specify) _____

16. Is this facility affiliated with any group ?

_____ Not affiliated
 _____ Religious _____
 _____ Fraternal _____
 _____ Commercial _____
 _____ Other (Please specify) _____

17. Among the following sources of income, which are the MAIN sources of income for this facility ? (Check all that apply).

_____ Resident's monthly payments
 _____ Subsidies from any source
 _____ Reimbursements (including medicaid and medicare)
 _____ Grants from any source
 _____ Other (Please specify). _____

18. In general, what has been the OCCUPANCY trend that best describes the years that this facility has been in operation?

_____ Occupancy has been DECREASING.
 _____ Occupancy has been INCREASING.
 _____ Occupancy has been STABLE.
 _____ Occupancy has been UNSTABLE and has changed.
 _____ Other (Please specify). _____

19. In a typical year, how many residents leave this facility ? (Please include ALL reasons for leaving including death, moving to another facility, loss of financial support, moving in with relatives, etc.).

20. Among the reasons listed, which are among the main reasons for resident turnover at this facility ?
(please check all that apply).

- ☐ Death.
 - ☐ Needs beyond those provided at this facility.
 - ☐ Inability to meet financial obligations.
 - ☐ Death of spouse.
 - ☐ Other (Please specify). _____
-

21. In general, where did these residents live immediately before moving into this facility ?

- ☐ Outside the State of Florida.
 - ☐ Inside Florida, but outside of this City/County.
 - ☐ Within this City or County.
 - ☐ Other (Please specify). _____
-

22. In general, which of the following describes the social contacts of the residents in this facility ?

- ☐ Most of the residents here have frequent visits with family or friends who do not live here.
- ☐ Most of the residents here rarely have visits from family or friends who do not live here.
- ☐ Most of the residents here never have visits from family or friends who do not live here.

23. In your opinion, if the residents of this facility were not living here, where would they live. (For example: Nursing homes, relatives homes, independent living arrangements, etc.).

Now we would like to ask a few questions relating to the organizational aspects of this facility. Again, please feel free to elaborate on the back of this form.

24. What is the total number of employees of this facility ?

_____ Number of employees.

25. Please break that number down by the categories listed below. (Please note: the term "Medical" refers only to those who provide MEDICAL care to the residents: Nurses, Nurses Aides, etc.).

	Non-Medical	Medical
1. Administrative	_____	_____
2. Other Salaried	_____	_____
3. Hourly	_____	_____
4. Part-time	_____	_____
5. Other	_____	_____
(specify) _____	_____	_____

26. What is the total number of employees who have terminated their employment in the last year for ALL reasons ?

_____ Number of employees.

27. Please break the number of terminations down by the categories listed below.

TERMINATIONS:	Non-Medical	Medical
1. Administrative	_____	_____
2. Other Salaried	_____	_____
3. Hourly	_____	_____
4. Part-time	_____	_____
5. Other	_____	_____
(specify)	_____	

28. Among the functions listed below, please place a check mark by the ones for which an employee devotes at least one-half of his or her time.

_____ Obtaining materials and equipment.
 _____ Recording financial dealings.
 _____ Controlling workflow.
 _____ Dealing with resident complaints.
 _____ Dealing with relatives of the residents.
 _____ Hiring new employees
 _____ Designing new programs or facilities.
 _____ Clerical.

29. Among the items listed below, please place a check mark by the ones for which the procedures and criteria are in written form.

_____ Application for employment.
 _____ Dismissal procedures.
 _____ Recruitment procedures for employment.
 _____ Job descriptions.
 _____ Definitions of specific tasks.
 _____ Organizational responsibilities of each department.

30. Which of the following best describes the management of this facility ?

_____ The Management is contracted out.
 _____ Managers are full-time employees.
 _____ Other (specify) _____

31. Apart from the normal regulatory agencies, are there other organizations or groups that exert or attempt to exert influence on the operation of this facility ? (For example: Religious sponsors, professional organizations, unions, business firms, etc.).

If yes, please specify the organization.

32. Are the program and/or service standards of this facility set or monitored by an outside organization ? (if yes, please specify the outside organization).

33. Among the organizations listed below, please place a check mark by those that, in the past year, have been the source of problems serious enough to require a reply by this facility.

a. Federal Level Regulatory Agencies:

- ☐ Department of Housing and Urban Development
☐ Social Security Administration
☐ Medicare Administration
☐ Other (specify) _____

b. State Level Regulatory Agencies:

- ☐ H.R.S.
☐ Department of Insurance
☐ Medicaid Administration
☐ Other (specify) _____

c. County Level Regulatory Agencies:

- ☐ Health Department
☐ Business License Bureau
☐ Building/Zoning Commission
☐ Other (specify) _____

d. Suppliers:

- ☐ Food suppliers
☐ Medical suppliers
☐ Office/business suppliers
☐ Contractors/builders
☐ Other (specify) _____

e. Other:

- _____ Parent corporation/sponsors
- _____ Residents Association
- _____ Employee Unions
- _____ Other (specify) _____

34. Has the facility encountered problems in the past year that you would describe as being generated from within the organization itself ? (if yes, please specify).

35. In the space provided, please place the number of the answer that best describes the relationship between this facility and the organizations listed below.

- 1= no disputes or disagreements.
- 2= a few disagreements or disputes.
- 3= disputes or disagreements are common.
- 4= disputes or disagreements are frequent.
- 5= disputes or disagreements are constant.

a. Federal Level Regulatory Agencies:

- _____ Department of Housing and Urban Development
- _____ Social Security Administration
- _____ Medicare Administration
- _____ Other (specify) _____

b. State Level Regulatory Agencies:

- _____ H.R.S.
- _____ Department of Insurance
- _____ Medicaid Administration
- _____ Other (specify) _____

c. County Level Regulatory Agencies:

- _____ Health Department
- _____ Business License Bureau
- _____ Building/Zoning Commission
- _____ Other (specify) _____

d. Suppliers:

- _____ Food suppliers
- _____ Medical suppliers
- _____ Office/business suppliers
- _____ Contractors/builders
- _____ Other (specify) _____

e. Other:

- _____ Parent corporation/sponsors
- _____ Residents Association
- _____ Employee Unions
- _____ Other (specify) _____

36. In the space provided, please place the number of the answer that best describes the basis for disputes of disagreements between this facility and the organizations listed below.

- 1= none
- 2= specific causes related to the day-to-day operation
- 3= different operating philosophies
- 4= personality differences
- 5= lack of communication
- 6= differences in power
- 7= other (specify) _____

a. Federal Level Regulatory Agencies:

- _____ Department of Housing and Urban Development
- _____ Social Security Administration
- _____ Medicare Administration
- _____ Other (specify) _____

b. State Level Regulatory Agencies:

- _____ H.R.S.
- _____ Department of Insurance
- _____ Medicaid Administration
- _____ Other (specify) _____

c. County Level Regulatory Agencies:

- _____ Health Department
- _____ Business License Bureau
- _____ Building/Zoning Commission
- _____ Other (specify) _____

d. Suppliers:

- _____ Food suppliers
- _____ Medical suppliers
- _____ Office/business suppliers
- _____ Contractors/builders
- _____ Other (specify) _____

e. Other:

- _____ Parent corporation/sponsors
- _____ Residents Association
- _____ Employee Unions
- _____ Other (specify) _____

37. In the space provided, please place the number of the answer that best describes how well YOU feel each of the organizations listed below performs its task. (whatever you define that task to be).

- 1= very poorly
- 2= poorly
- 3= adequately
- 4= well
- 5= very well

a. Federal Level Regulatory Agencies:

- _____ Department of Housing and Urban Development
- _____ Social Security Administration
- _____ Medicare Administration
- _____ Other (specify) _____

b. State Level Regulatory Agencies:

- _____ H.R.S.
- _____ Department of Insurance
- _____ Medicaid Administration
- _____ Other (specify) _____

c. County Level Regulatory Agencies:

- _____ Health Department
- _____ Business License Bureau
- _____ Building/Zoning Commission
- _____ Other (specify) _____

d. Suppliers:

- _____ Food suppliers
- _____ Medical suppliers
- _____ Office/business suppliers
- _____ Contractors/builders
- _____ Other (specify) _____

e. Other:

- _____ Parent corporation/sponsors
- _____ Residents Association
- _____ Employee Unions
- _____ Other (specify) _____

38. In the space provided, please place the number of the answer that you think best describes the quality of communications between this facility and the organizations listed below.

1= very poor
 2= poor
 3= adequate
 4= good
 5= very good

a. Federal Level Regulatory Agencies:

_____ Department of Housing and Urban Development
 _____ Social Security Administration
 _____ Medicare Administration
 _____ Other (specify) _____

b. State Level Regulatory Agencies:

_____ H.R.S.
 _____ Department of Insurance
 _____ Medicaid Administration
 _____ Other (specify) _____

c. County Level Regulatory Agencies:

_____ Health Department
 _____ Business License Bureau
 _____ Building/Zoning Commission
 _____ Other (specify) _____

d. Suppliers:

_____ Food suppliers
 _____ Medical suppliers
 _____ Office/business suppliers
 _____ Contractors/builders
 _____ Other (specify) _____

e. Other:

_____ Parent corporation/sponsors
 _____ Residents Association
 _____ Employee Unions
 _____ Other (specify) _____

39. If substantial changes in the operation or the philosophy of this facility were determined to be necessary, how would the decisions to implement those changes be made ?
40. Who decides the long-range policies of this facility ?
41. What are some of the most important problems that this facility has had to deal with, or will have to deal with in the near future ?
42. What are the major changes that you have observed since this facility was established ?
43. AUTONOMY can be defined as the extent to which one organization is free of influence from other organizations. In the space provided, please place the number of the answer that best describes your assessment of the autonomy of this facility when compared with the organizations listed below.
- 1= completely autonomous (i.e., no influence)
 - 2= somewhat autonomous (i.e., some influence)
 - 3= somewhat not autonomous (i.e., heavy influence)
 - 4= completely not autonomous (i.e., domination)
- a. Federal Level Regulatory Agencies:
- _____ Department of Housing and Urban Development
 - _____ Social Security Administration
 - _____ Medicare Administration
 - _____ Other (specify) _____

b. State Level Regulatory Agencies:

☐ H.R.S.
☐ Department of Insurance
☐ Medicaid Administration
☐ Other (specify) _____

c. County Level Regulatory Agencies:

☐ Health Department
☐ Business License Bureau
☐ Building/Zoning Commission
☐ Other (specify) _____

d. Suppliers:

☐ Food suppliers
☐ Medical suppliers
☐ Office/business suppliers
☐ Contractors/builders
☐ Other (specify) _____

e. Other:

☐ Parent corporation/sponsors
☐ Residents Association
☐ Employee Unions
☐ Other (specify) _____

44. POWER can be defined as the extent to which one organization can influence operation of another organization. In the space provided, please place the number of the answer that best describes your assessment of the power of this facility when compared to the organizations listed below.

- 1= much more powerful
- 2= more powerful
- 3= equally powerful
- 4= less powerful
- 5= much less powerful

a. Federal Level Regulatory Agencies:

☐ Department of Housing and Urban Development
☐ Social Security Administration
☐ Medicare Administration
☐ Other (specify) _____

b. State Level Regulatory Agencies:

☐ H.R.S.
☐ Department of Insurance
☐ Medicaid Administration
☐ Other (specify) _____

c. County Level Regulatory Agencies:

☐ Health Department
☐ Business License Bureau
☐ Building/Zoning Commission
☐ Other (specify) _____

d. Suppliers:

☐ Food suppliers
☐ Medical suppliers
☐ Office/business suppliers
☐ Contractors/builders
☐ Other (specify) _____

e. Other:

☐ Parent corporation/sponsors
☐ Residents Association
☐ Employee Unions
☐ Other (specify) _____

45. Listed below are a number of decision-making tasks.

Please indicate, by title, the lowest ranking member of this organization who would have the POWER to make the decision.

- a. Establish supervisory positions
- b. Appoint supervisory staff from outside the organization
- c. Promote supervisory staff from within the organization
- d. Set salaries of supervisory staff
- e. Dismiss supervisory staff
- f. Select non-supervisory staff
- g. Design and/or implement new programs or services

- h. Set fee structure
 - i. Decide the type and brand of equipment for purchase
 - j. Decide the methods of work to be used
 - k. Allocate work
 - l. Set resident admission standards
 - m. Allocate funds
 - n. Assign supervisory responsibility
 - o. Design and/or create new facilities
46. Many continuing care facilities have formal charts that graphically represent the interrelationships between and among their organizational elements. It would very useful for us to have a copy of your organizational chart. If such a chart already exists, we would very much appreciate it if you could include it when you mail this form back to us. If there is no such chart, could you please provide a brief sketch, on the back of this form, describing your organization.
47. It would also be helpful if you could include a copy of your latest fee schedule. If none is available, please give us some indication of the monthly costs of your facility, entrance fees, if any, and any other costs that an individual would normally pay to be a resident of your facility.

Thank you very much for your time and your cooperation. Please return this form in the enclosed envelope. No postage is necessary.

APPENDIX B
CORRELATION COEFFICIENTS FOR THE CAPACITY,
NUMBER OF ORGANIZATIONAL DIVISIONS, AND
ORGANIZATIONAL LEVELS OF FLORIDA'S CONTINUING
CARE RETIREMENT COMMUNITIES.

	Capacity	Number of Divisions	Number of Levels
Capacity	1.000	0.331	0.203
Number of Divisions	0.331	1.000	0.131
Number of Levels	0.203	0.131	1.000
<hr/> p < .05			

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William Edward Folts was born May 10, 1950, in Tuscaloosa, Alabama, where he graduated from Tuscaloosa High School in 1968. He received a Bachelor of Science degree from the University of Alabama in 1977 and a Master of Science degree from the University of Alabama in 1979.

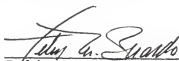
Between 1979 and 1983 he worked as a research associate in the Center for Gerontological Studies at the University of Florida.

I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Philosophy.



Gordon F. Streib, Chairman
Graduate Research Professor of Sociology

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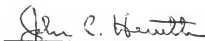


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May 1987

Dean, Graduate School